

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6464 CERTIFICATE OF DEATH

06423

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Madlyn</b> Last <b>Abernathy</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 15, 1912</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>14</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lynette Heuser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Melanoma in Brain, Lungs</b> <b>190x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Liver Heart Kidneys</b> DUE TO (c) <b>Malignant Melanoma</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>600.0</b> <b>Pyelonephritis due to E. coli</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 28</b> , 19 <b>57</b> , to <b>June 17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 17</b> , 19 <b>57</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur J. Garceau</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Arthur J. Garceau, M. D.</b>		DATE SIGNED <b>6/18/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JUNE 21-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VIRGINIA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington Funeral Home</b>		24a. REC'D. BY REGISTRAR <b>DATE 21 1957</b>	
ADDRESS <b>3901 W. Fairfax Rd.</b> <b>Arlington Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Debbie Thompson</b>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		New York City		New York City		Heart Disease		1957		10:00 AM		Home		J. Smith		A. Jones	
Occupation		Marital Status		Previous Illnesses		Date of Last Examination		Date of Death		Date of Burial		Place of Burial		Date of Interment		Place of Interment		Date of Cremation		Place of Cremation		Date of Disposition	
Teacher		Married		Hypertension		1956		1957		1957		Catholic Church		1957		Catholic Church		1957		Catholic Church		1957	

BUREAU V. E.

JUN 21 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6465

## CERTIFICATE OF DEATH

06424

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>67 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>2211 Onslow Drive</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice Clarissa Albert</b>		4. DATE OF DEATH Month Day Year <b>June 27 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 December 1919</b>
9. AGE (In years last birthday) <b>37 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>6 11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William D. Morse</b>		14. MOTHER'S MAIDEN NAME <b>Clarissa Tyler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive FAILURE</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral INSUFFICIENCY</b> DUE TO (c) <b>Rheumatic fever</b>			INTERVAL BETWEEN ONSET AND DEATH <b>known</b> <b>6 months</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>21 April 1957</b> to <b>27 June 1957</b> , that I last saw the deceased alive on <b>27 June 1957</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center</b> <b>6/28/57</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/28/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Walnut Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Baraboo, Wisconsin</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>6-30-57</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. B.

JUL 2 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6466

## CERTIFICATE OF DEATH

06425

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN b. <b>15 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie=</b> Middle <b>Allnutt</b> Last <b>Allnutt</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/93</b>
9. AGE (In years last birthday) yrs. <b>64</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George E. Brown</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Young</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Hospital Record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Complete Heart Block</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>433.0</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. 51</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5/26</b> , 19 <b>57</b> , to <b>6/9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/9</b> , 19 <b>57</b> , and that death occurred at <b>12:30AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED <b>6/10/57</b>			
ACTUAL SIGNATURE <b>A. D. Bonifant</b>		PHYSICIAN'S NAME (Type) <b>A. D. Bonifant, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 12</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Claggettville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Barber</b>		24a. REC'D BY REGISTRAR DATE <b>6/13/57</b>	
ADDRESS <b>Laytonsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>B. Lawrence</b>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. 3

JUN 21 1957

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 11 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6467

Reg. Dist. No. 06426  
218

1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>15yrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Asbury Methodist Home</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle <b>Brown</b> Last <b>Althoff</b>				4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 13-1869</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>8</b>		IF UNDER 24 HRS. Hours <b>8</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>		11. BIRTHPLACE (State or foreign country) <b>Culpepper, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>1</b>							
13. FATHER'S NAME <b>John Thomas Brown</b>				14. MOTHER'S MAIDEN NAME <b>Susan Jane Edwards</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>1</b>				16. SOCIAL SECURITY NO. <b>Asbury Methodist Home Records.</b>			
17. INFORMANT <b>Gaithersburg Md</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REBURY (Type) <b>Burial</b>				22b. DATE THEREOF <b>6-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fair View</b>	
22d. LOCATION (City, town, or county) (State) <b>Culpepper, Va.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner</b>				24a. REC'D BY REGISTRAR <b>June 22-57</b>		24b. REGISTRAR'S SIGNATURE <b>Abner L. Cooke</b>	

MEDICAL CERTIFICATION

# DEPARTMENT OF HEALTH - DIVISION OF MEDICAL EXAMINERS - CERTIFICATE OF DEATH

BUREAU No. 1

JUN 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06427

## 6468 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Colorado</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denver</b> <b>448-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>3030 East 17th Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herman</b> Middle Last <b>Appel</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1879</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cigar Maker (Retired)</b>	11. BIRTHPLACE (State or foreign country) <b>Russia</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cigar Maker (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Louis Appel</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tot. no. or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Leonard Appel</b>		Address <b>4004 Virgilia, Chevy Chase, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO (c) <b>PULMONARY EMBOLI, RECURRENT</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 YEARS</b> <b>4 WEEKS</b> <b>3 WEEKS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>434.1</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <b>19</b> p. m. Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>MAY 1</b> , 19 <b>57</b> , to <b>JUNE 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>JUNE 9</b> , 19 <b>57</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip R. James</b>		ADDRESS (Street, city or town, state) <b>6921-CLARENDON Rd. Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Philip R. James</b>		DATE SIGNED <b>6-13-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Nebo Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Denver, Colorado</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Warginsky &amp; Sons</b>		ADDRESS <b>3501 14th St., N. W.</b>	24a. REC'D BY REGISTRAR <b>6-13-57</b>
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	



IN WYOMING STATE DEPARTMENT OF HEALTH - BULLETIN, 19

JUN 17 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6435

## CERTIFICATE OF DEATH

06428

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 days</u>		d. STREET ADDRESS <u>602 Easley St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Marie</u> Last <u>Bakersmith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 18, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Am. Express</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Burns</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>578-01-1253</u>	
17. INFORMANT <u>hosp Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
DUE TO <u>hemorrhage from Esophageal Varices</u>		3 weeks	
DUE TO <u>Cirrhosis of Liver (Laennec's)</u>		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis &amp; Cystitis; Glomerulonephritis; Nephrolithiasis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1952</u> to <u>June 17, 1957</u> , that I last saw the deceased alive on <u>June 17, 1957</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N.C. Shoemaker, M.D.</u>		ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>N.C. SHOEMAKER, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/20/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>6/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>William P. Pold</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. R.

JUN 21 1957

RECEIVED

6469

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hosp.</b>				e. STREET ADDRESS <b>4833 Broad Brook Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Victor Stanislaus Baril</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1899</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Economist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Labor</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Archie Baril</b>				14. MOTHER'S MAIDEN NAME <b>Victoria Brisson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Margaret Baril</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple myeloma</b> <b>X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>521X</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lung Abscess, Right Lower Lobe</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5, 1957</b> , to <b>June 23, 1957</b> , that I last saw the deceased alive on <b>June 23, 1957</b> , and that death occurred at <b>6:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Dr. Joseph Kenrick</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>6450 Wisconsin Ave, Bethesda Md 6/23/57</b>			
PHYSICIAN'S NAME (Type) <b>DR. JOSEPH KENRICK</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 6-24-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

IN 6 1957

BUREAU V. B.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6470

## CERTIFICATE OF DEATH

06430

Reg. Dist. No. 211

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Purdu</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Purdu</b>	
		d. STREET ADDRESS <b>Monrovia Rfd</b>	
		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Beall</b>		4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec, 28 1865</b>
		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Benjamin Franklin Burdette</b>		14. MOTHER'S MAIDEN NAME <b>Charity Ane Watkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>####</b>		16. SOCIAL SECURITY NO <b>None</b>	
		17. INFORMANT <b>Mrs. Emma E. Beall</b> Address <b>Monrovia R.F.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January</b> , 19 <b>35</b> , to <b>June 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 18</b> , 19 <b>57</b> , and that death occurred at <b>11:45 P.M.</b> My from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Druid Theatre Building</b> DATE SIGNED <b>June 19, 1957</b>			
ACTUAL SIGNATURE <b>M. McKendree Boyer, M.D.</b>		DATE SIGNED <b>June 19, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Dr. McKendree E. Boyer</b>		ADDRESS <b>Damascus Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 21 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mountain View</b>	22d. LOCATION (City, town, or county) (State) <b>Purdu Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond S. Barber</b>		24a. REC'D BY REGISTRAR DATE <b>June 21 57</b>	
ADDRESS <b>Laytonsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Della W. Burdette</b>	

RECEIVED

JUN 27 1957

BUREAU V. S.

6471

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution residence before admission) o STATE <u>MARYLAND</u> b COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1615	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marlen Nursing Home</u>		d. STREET ADDRESS <u>2028-Powhatan Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA KATHARINA BECK</u>		4. DATE OF DEATH Month Day Year <u>June 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1891</u> 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. PLACE (State or foreign country) <u>Washington D.C.</u>
13. FATHER'S NAME <u>Kornel Weiss</u>		14. MOTHER'S MAIDEN NAME <u>Marie Louis Gottschling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. James Noble</u>		Address <u>Niece</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senescent arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-5-57</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 19, 1954</u> , to <u>June 19, 1957</u> , that I last saw the deceased alive on <u>June 15, 1957</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Rogers</u> M.D.		ADDRESS (Street, city or town, state) <u>1519 Seminary Rd. Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert J. Rogers</u>		DATE SIGNED <u>6-19-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 21, 1957</u>		22b. DATE THEREOF	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tom Lee &amp; Sons</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-24-57</u>	24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 26 1957

BUREAU V. I.

6436

## CERTIFICATE OF DEATH

Reg. Dist. No.

177

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
c. LENGTH OF STAY in lb <u>17 days</u>				d. STREET ADDRESS <u>5720 29th Ave Apt 102</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lee</u> Last <u>Bell</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>coll</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-7-79</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSSI</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>V9</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jesse Ruffner</u>				14. MOTHER'S MAIDEN NAME <u>Emma Ball</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Hosp Records</u>			
17. INFORMANT <u>Hosp Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal hemorrhage</u>							<u>14 days</u>
151X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Carcinoma of pancreas</u>							<u>Weeks</u>
DUE TO							
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 25, 1957</u> , to <u>June 6, 1957</u> , that I last saw the deceased alive on <u>June 5, 1957</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M D <u>7105 Riggs Rd. Hyattsville, Md.</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery Prince George County, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>2401 14th St. N.W. Washington, D.C.</u>			
24b. REGISTRAR'S SIGNATURE				DATE <u>JUN 7 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. B.

MAY 2 1967

RECEIVED

6472

CERTIFICATE OF DEATH

Reg. Dist. No.

06433

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>At Home</b>		d. STREET ADDRESS <b>2402 Lindell Street</b>	
3. NAME OF DECEASED (Type or print) First <b>RUSSELL</b> Middle <b>M.</b> Last <b>BEVLIN</b>		4. DATE OF DEATH Month <b>6</b> Day <b>9</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 12, 1900</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Cab Driver</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Cab Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WEST VIRGINIA</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1923-1928</b>	
17. INFORMANT <b>Silver Spring, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary insufficiency</b> DUE TO (c) <b>Coronary sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>1 year</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10, 1956</b> to <b>June 29, 1957</b> , that I last saw the deceased alive on <b>June 8, 1957</b> , and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Daniel B. Washington</b> M.D. <b>6234 24 Ave NW Washington DC 4/5/57</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Daniel B. Washington M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-12-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Collins</b> ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE <b>F. Collins</b>		DATE <b>JUN 12 1957</b>	

BUREAU V. S.

JUN 12 1957

RECEIVED

## 6473 CERTIFICATE OF DEATH

Reg. Dist. No. 214

## 1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) 40 yrs.  
 OR and give nearest town)  
 TOWN Silver Spring  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 10,203 Brookmoor Drive

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Montgomery  
 CITY (If outside corporate limits, write RURAL and give nearest town) 40 yrs.  
 OR and give nearest town)  
 TOWN Silver Spring  
 STREET ADDRESS (If rural give location) 10,203 Brookmoor Drive

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Julian William Bieber

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

June 919 57

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 MRS.

malewhitedivorcedJuly 10, 189957yrs.MonthsDaysHoursMin.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

Carpenter

## 10b. KIND OF BUSINESS OR INDUSTRY:

Building

## 11. BIRTHPLACE (State or foreign country):

D. C.

## 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME:

Henry J. Bieber

## 14. MOTHER'S MAIDEN NAME:

Lissetta R. Huth

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

## 16. SOCIAL SECURITY No.:

214-03-9439

## 17. INFORMANT &amp; ADDRESS:

Mrs. Carlotta B. Jackson, 10,203 Brookmoor Dr.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral thrombosis

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ...(c) ...

Interval Between Onset And Death

3 weeks

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 17, 1957, to June 9, 1957, that I last saw the deceasedalive on May 3, 1957 and that death occurred at 3:00 am, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

6-17-57Francis PotterWarner E. PumphreySilver Spring, Md.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 19 1957

RECEIVED

# CERTIFICATE OF DEATH

Reg. Dist. No.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE  
CORNISH + Cornish 2121-10-St N.W. JUL 5 1955 Bessie Thompson

VS A15 (4)  
15M 9/SS

RECEIVED

JUL 5 1957

BUREAU V. S.



6475

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY in 1b <b>6 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1520 EAST-WEST HIGHWAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>McINTOSH</b> Last <b>BOONE</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 13, 1883</b>
9. AGE (In years last birthday) <b>74</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>registered nurse - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mississippi</b>	
11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN A. McINTOSH</b>		14. MOTHER'S MAIDEN NAME <b>JANE CARLOS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Minnie B. McIntosh, 1520 East-West Highway Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic Heart Disease</b> <b>4 1/2 yrs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> <b>4 years</b> DUE TO (c) <b>Congestive Heart Failure</b> <b>4 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1, 1956</b> to <b>June 15, 1957</b> , that I last saw the deceased alive on <b>June 15, 1957</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10220 Georgia Ave Silver Spring, Md.</b> DATE SIGNED <b>6/15/57</b>			
ACTUAL SIGNATURE <b>John J. Curry</b> M.D.		PHYSICIAN'S NAME (Type) <b>JOHN J. CURRY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL 6/16/57</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MEMPHIS, TENNESSEE</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter S. Tompkins, SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>6/15/57</b>	
		24b. REGISTRAR'S SIGNATURE <b>James Latta</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 4 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 19 1957

6437

CERTIFICATE OF DEATH

06437

77.3

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>4 1/2 HRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Soc. of Hosp.</u>				d. STREET ADDRESS <u>6 E. Ridge Road.</u>			
3. NAME OF DECEASED (Type or print) First <u>Jeffrey</u> Middle <u>Beachum</u> Last <u>Breashers</u>				4. DATE OF DEATH Month <u>6</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-9-55</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Royal Polan Breashers</u>				14. MOTHER'S MAIDEN NAME <u>Vera Beachum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Chart</u> Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Viral Hepatitis</u> <u>5524</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/9</u> 19 <u>55</u> , to <u>6/14</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6/14</u> 19 <u>57</u> and that death occurred at <u>6:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12126 Vicksburg Rd - 6/14/57</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Charles Farwell</u> M.D.				PHYSICIAN'S NAME (Type) <u>CHARLES FARWELL</u> <u>Wharton Md</u>			
22a. BURIAL, CREMATION, or other disposition <u>Burial</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		22d. LOCATION (City, town, or county) (State) <u>Kitty Hawk, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. W. Chambers</u> ADDRESS <u>5801 Kerchard Ave</u>				24a. REC'D BY REGISTRAR <u>JUN 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. W. Chambers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 18 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6476

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06438

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> <b>83X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Off Md. R-355, 1 1/2 mi. W Clarksburg</b>			d. STREET ADDRESS <b>507 Rossiter St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Ross</b> Last <b>Burke</b>			4. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>57</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/2025</b>	9. AGE (In years last birthday) <b>30</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pilot</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Airline Transport</b>		11. BIRTHPLACE (State or foreign country) <b>Arizona</b>	
13. FATHER'S NAME <b>Spencer A. Burke</b>			14. MOTHER'S MAIDEN NAME <b>Mary E. Ross</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>567-26-0311</b>		17. INFORMANT Address <b>Capital Airline Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries, Extreme</b> DUE TO (b) <b>Body &amp; Extremities badly Mutilated</b> DUE TO (c) <b>Body &amp; Extremities badly Mutilated</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Airplane Accident</b>			
20c. TIME OF INJURY Month, Day, Year <b>9:00 a.m. 6/22/57</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Country</b>		
		20f. (City or town) <b>Clarksburg Montg. Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank J. Brosehart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/22/57</b>	
EXAMINER'S NAME (Type) <b>Frank J. Brosehart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 25, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Everly Funeral Home By</b>		ADDRESS <b>Mgr. Fairfax, Va.</b>		24a. RECEIVED BY REGISTRAR <b>JUN 28 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Lansell Drayton</b>	

RECEIVED

JUN 28 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6477

## CERTIFICATE OF DEATH

06439

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>3 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>704 McNeil Road</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>704 McNeil Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ISAAC</b> Middle <b>RAYMOND</b> Last <b>BURTON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>24</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Route man (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Congress Laundry</b>	9. AGE (In years lost birthday) <b>70</b> yrs. IF UNDER 1 YEAR: Months <b>24</b> Days <b>19</b> Hours <b>57</b> Min
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER T. BURTON</b>		14. MOTHER'S MAIDEN NAME <b>EDNA A. ATHINSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>578-24-7819</b>	17. INFORMANT <b>Mrs. Elsie M. Burton, 704 McNeil Rd. Silver Spring, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured aneurysm of abdominal aorta</b> <b>451x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac decompensation</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac decompensation</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/22</b> to <b>6/24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>1/22</b> , 19 <b>55</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>9006 Glenview Rd Silver Spring, Md</b> DATE SIGNED <b>6/24/57</b>			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		PHYSICIAN'S NAME (Type) <b>William D. Aud</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/26/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BURTONSVILLE CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BURTONSVILLE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lawrence E. Pumpfery</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>6/30/57</b>	24b. REGISTRAR'S SIGNATURE <b>Francis J. [unclear]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



U. S. A.

1957

U. S. A.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6478

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06440

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8615 Brandt St.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Duncan Cameron Campbell</b>		4. DATE OF DEATH Month Day Year <b>June 6 1957 19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/1887</b>
9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Exec. officer retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>F.H.A.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa,</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James L. Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Same as # 2</b>	
17. INFORMANT <b>Rose Campbell</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carbon monoxide Poisoning</b> DUE TO (c) <b>Found dead in car at home</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in car at home</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found dead in car in closed garage at home</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>3:30</b> p. m. <b>6/6/57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		DATE SIGNED <b>6/6/57</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 6-7-57</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dauphin Co. Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24a. REC'D BY REGISTRAR <b>6-8-57</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Bea M. Thompson</b>	

RECEIVED

JUN 11 1957

BUREAU W. S.

6479

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Disarriet of Columbia</b> b. COUNTY <b>Washington 16,</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>9 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hosp.</b>				d. STREET ADDRESS <b>5117 Westridge Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Lee</b> Last <b>Canada</b>				4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 5, 1872</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Retired.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>INSURANCE</b>		11. BIRTHPLACE (State or foreign country) <b>ARKANSAS</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JESSIE E MARTIN</b>				14. MOTHER'S MAIDEN NAME <b>SARAH (UNKNOWN)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>578-05-2665</b>		17. INFORMANT <b>JOE HICKS - SON</b> Address <b>5117 Westridge Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Internal Myocardial Infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Atherosclerosis</b> (c) <b>10 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>100x Diabetes Mellitus</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>June 1955</b> , to <b>June 22, 1957</b> , that I last saw the deceased alive on <b>June 22, 1957</b> , and that death occurred at <b>9:20 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Michel M. Healy</b>				DATE SIGNED <b>June 22, 1957</b>			
PHYSICIAN'S NAME (Type) <b>Michel M. Healy</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial-Transit</b>		<b>6-23-57</b>		<b>Roselawn Cemetery</b>		<b>Pulaski, Arkansas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-24-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

6438		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		06442	
CERTIFICATE OF DEATH				Reg. Dist. No. 223	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Md.</b>		c. LENGTH OF STAY IN 1b <b>less 1 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sen + Hosp</b>		d. STREET ADDRESS <b>325 University Blvd. E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>none</b> Last <b>CAPLAN</b>		4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-1892</b>	9. AGE (In years last birthday) <b>65 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Manager (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wine + Liquors</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Harry Leon Caplan</b>		14. MOTHER'S MAIDEN NAME <b>not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Not known</b>		17. INFORMANT <b>Son (Irving Caplan)</b> Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>CORONARY THROMBOSIS + MYOCARDIAL INFARCTION</b> (c) <b>24 HRS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 HRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>6/17</b> , 19 <b>57</b> , to <b>11:00 AM</b> 19 <b>57</b> that I last saw the deceased alive on <b>6/17</b> , 19 <b>57</b> , and that death occurred at <b>11:00 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state). <b>1352 UNIVERSITY LANE</b> DATE SIGNED <b>Harold Sterling</b>					
ACTUAL SIGNATURE <b>Harold Sterling</b> M.D.					
PHYSICIAN'S NAME (Type) <b>HAROLD STERLING</b>		<b>HYATTSVILLE MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Adams Memorial Co.</b>	22d. LOCATION (City, town, or county) (State) <b>Nashington DC</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Wanyanahy + Sons</b> ADDRESS <b>3501-142</b>		24a. REG'D BY REGISTRAR <b>50</b> DATE <b>6/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Thon</b>	

BUREAU V. S.

JUN 21 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6480

CERTIFICATE OF DEATH

06443

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>130 days</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Prince William</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nokesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>R. D. 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Fitzwater Carrico</b>		4. DATE OF DEATH Month Day Year <b>June 1, 19 57</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>February 28, 1925</b>	9. AGE (In years last birthday) <b>32 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Correctional Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Reformatory</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13 FATHER'S NAME <b>John Henry Carrico</b>		14 MOTHER'S MAIDEN NAME <b>Ada Angeline Fitzwater</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW 2</b>		16 SOCIAL SECURITY NO <b>None</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>192X</b> <b>respiratory paralysis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic chorocarcinoma</b> DUE TO (c) <b>mos.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21 I certify that I attended the deceased from <b>January 22, 1957</b> , to <b>June 1, 19 57</b> , that I last saw the deceased alive on <b>June 1, 19 57</b> , and that death occurred at <b>11 P. M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>6-2-57</b> ACTUAL SIGNATURE <b>S. Weissman</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>SHERMAN WEISSMAN, M. D.</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 4 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Stonewall Memory Garden</b>	22d. LOCATION (City, town or county)	(State)	
23 FUNERAL DIRECTOR'S SIGNATURE <b>F. E. Hutcherson</b>		ADDRESS <b>Hyattsville Md</b>	24a. REC'D BY REGISTRAR <b>JUN 6 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Lucius Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 6 1957

RECEIVED

6431

## CERTIFICATE OF DEATH

06444

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN IB <b>36 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				e. STREET ADDRESS <b>4 Magnolia Parkway</b>			
3. NAME OF DECEASED (Type or print) First <b>Floyd</b> Middle <b>James</b> Last <b>CARTER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 7, 1893</b>	
9. AGE (In years last birthday) <b>64</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chiropractor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chiropractic Physiotherapy</b>		11. BIRTHPLACE (State or foreign country) <b>North Dakota</b>	
13. FATHER'S NAME <b>George C. CARTER</b>				14. MOTHER'S MAIDEN NAME <b>Annabelle RHODES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-38-1365</b>		17. INFORMANT Address <b>Wife, Elsie Beatrice CARTER (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>arterio-sclerotic heart disease</b> (b) <b>Arterio-sclerotic heart disease</b> (c) <b>Arterio-sclerotic's generalized</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Indefinite</b> <b>Indefinite</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> m. <b>19</b>			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County) (State)			
21. I certify that I attended the deceased from <b>May 14</b> , 1957, to <b>June 19</b> , 1957, that I last saw the deceased alive on <b>June 18</b> , 1957, and that death occurred at <b>8:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 6-19-57</b>							
ACTUAL SIGNATURE <b>Thomas H. Ushafer</b> M.D.				PHYSICIAN'S NAME (Type) <b>Thomas H. Ushafer, CDR, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. REGISTRAR'S SIGNATURE <b>R.A. Pumphrey</b>				24a. REC'D BY REGISTRAR DATE <b>6-19-57</b>			
24b. REGISTRAR'S SIGNATURE <b>Mary E. Farrelly</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6482

CERTIFICATE OF DEATH

06445  
212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington</b> D.C. b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Poolesville, R.F.D.</b>				c. LENGTH OF STAY IN Jb <b>2 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Matthews Nursing Home</b>				d. STREET ADDRESS <b>4311 Argyle Terrace, N.W.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>Smith</b> Last <b>Chiswell</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 57</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 26-1885</b>		9. AGE (In years last birthday) <b>71</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Smith</b>				14. MOTHER'S MAIDEN NAME <b>Katie Schwartz</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Whitney Sweeney, 4311 Argyl Terrace, Washington</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>3 years</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>147X</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1954, to <b>3 June</b> , 1957, that I last saw the deceased alive on <b>3 June</b> , 1957, and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>John M. Smith</b>				ADDRESS (Street, city or town, state) <b>RFD Boyd, Maryland</b> DATE SIGNED <b>4 June 57</b>					
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Helton</b>				ADDRESS <b>Barnesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6/4/57</b>		24b. REGISTRAR'S SIGNATURE <b>Charles W. Elgin</b>	

RECEIVED

JUN 7 1957

BUREAU V. S.

6483

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

06446

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>4426 Volta Place, N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Bladen</b> Middle <b>Dulany</b> Last <b>CLAGGETT, Jr.</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 4, 1939</b>	
9. AGE (In years last birthday) <b>17 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Student</b>			
11. BIRTHPLACE (State or foreign country) <b>Canal Zone</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Bladen Dulany CLAGGETT</b>				14. MOTHER'S MAIDEN NAME <b>Rhea A. ROBINSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>Unknown</b>			
17. INFORMANT <b>Father, Bladen D. CLAGGETT (Same as #2)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain tumor, basilar; type unknown</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 22</b> , 1957, to <b>June 5</b> , 1957, that I last saw the deceased alive on <b>June 5</b> , 1957, and that death occurred at <b>2:52 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 6-7-57</b>							
ACTUAL SIGNATURE <b>Burt C. Johnson</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Burt C. Johnson, LCDR, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's &amp; Sons</b>				ADDRESS <b>Wash., D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>6-6-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In auto at Old Montg. Co. Home</b>				d. STREET ADDRESS <b>601 Anderson Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julian</b> Middle <b>Keen</b> Last <b>Cochran</b>				4. DATE OF DEATH Month <b>6</b> Day <b>18</b> Year <b>57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/14/12</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levi W. Cochran</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-07-0955</b>		17. INFORMANT <b>Mrs. A.F. Beane- 129 S. Adams St. Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO <b>400.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found dead in auto of his car</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>6/18/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union Cem.</b>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>June 21 57</b>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06448

6484

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3609 Lawrence Ave.</b>				d. STREET ADDRESS <b>3609 Lawrence Ave</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>NORA</b> First		Middle <b>D.</b> Last <b>COCHRAN</b>		4. DATE OF DEATH <b>June 24,</b> Month Day Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/1892</b>	9. AGE (In years last birthday) <b>64</b> yrs	IF UNDER 1 YEAR Months <b>6</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Joe Alexander Miller</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Holt Glover</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-20-1916</b>		17. INFORMANT Address <b>James L. Clark- Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>354X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypostasis</b> (c) <b>Cerebral Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b> <b>7 days</b> <b>Many Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bad Patient for year</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 1953</b> to <b>June 24, 1957</b> , that I last saw the deceased alive on <b>June 24, 1957</b> , and that death occurred at <b>10/55</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bradley D. Hodgkins M.D.</b>				ADDRESS (Street, city or town, state) <b>4413 Bradley Lane</b>			
PHYSICIAN'S NAME (Type) <b>Bradley D. Hodgkins-4413 Bradley Lane, Chevy Chase, Md.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Geo. Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>6-27-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. [Signature]</b>			

BUREAU V. S.

JUL 1 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6485

CERTIFICATE OF DEATH

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216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. LENGTH OF STAY IN 1b <u>1 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden San.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brockdale</u>			
				d. STREET ADDRESS <u>4608 Overbrook Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Frances</u> First Middle Last				4. DATE OF DEATH <u>June 28 1957</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1867</u> 9. AGE (In years lost birthday) <u>90</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales lady</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Grant Mickum</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Paul H. Doerr</u> Address <u>4608 Overbrook Rd - Brockdale Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, severe, generalised</u> DUE TO (c) <u>Advanced senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9. 27. 1956</u> to <u>June 28, 1957</u> , that I last saw the deceased alive on <u>June 27, 1957</u> , and that death occurred at <u>5:24 A.M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Stewart Clapp</u>				ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW. Wash. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				DATE SIGNED <u>6-28-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivert Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J Lee &amp; Sons 300 4th St N.E. Wash DC</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 7-3-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M Thompson</u>			

Advanced activity  
 Afternoon, 2:00-3:00  
 General Thompson, 3:00-4:00

RECEIVED  
 1957  
 341 Indiana St. N.W.  
 BUREAU V. 1  
 22 June 55

Stewart G. Cobb  
 General

6486

CERTIFICATE OF DEATH

06449  
216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		d. STREET ADDRESS <b>302 Adelaide Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ruby</b> Middle <b>Louise</b> Last <b>Conard</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/87</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Loudon County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Edward S. Benjamin</b>		14. MOTHER'S MAIDEN NAME <b>Mary Etta Hardy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Louise Towles</b>		Address <b>302 Adelaide Drive</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b> <b>4 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>444X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>SEPT. 1953</b> to <b>JUNE 22, 1957</b> that I last saw the deceased alive on <b>JUNE 22, 1957</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo M. Curtis</b> M.D.		ADDRESS (Street, city or town, state) <b>8218 Wisconsin Ave. Bethesda, Md.</b>	
DATE SIGNED <b>6/22/57</b>			
PHYSICIAN'S NAME (Type) <b>Leo M. Curtis</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/25/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Washington 18, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington Funeral Home</b> ADDRESS <b>3901 North Fairfax Drive, Arlington, Virginia</b>		24a. REC'D BY REGISTRAR <b>JUN 25 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



BUREAU V. E.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06450

6487

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hosp. Route 3</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>Route 3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Floyd</b> First <b>Wallace</b> Middle <b>CREGLOW</b> Last <del>XXXXXX</del>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1908</b> 9. AGE (In years last birthday) <b>49</b> yrs. IF UNDER 1 YEAR: Months <b>2</b> Days <b>17</b> IF UNDER 24 HRS.: Hours <b>17</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electric Tec.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Stand.</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>George B. Creglow</b>		14. MOTHER'S MAIDEN NAME <b>Mary Luther</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW 2</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Dr. A. J. Janes</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Hepatic Flexure of Colon</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>211x</b> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Multiple Polypoidosis of Colon</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>11</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 3</b> , 1957, to <b>June 4</b> , 1957, that I last saw the deceased alive on <b>June 4</b> , 1957, and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Rockville - Md.</b> DATE SIGNED <b>6/4/57</b>			
ACTUAL SIGNATURE <b>Arthur F. Woodward</b> M.D.		DATE SIGNED <b>6/4/57</b>	
NAME (Type) <b>Robert A. Pumphrey</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>6/7/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Beneden Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bridgeport, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>6/8/57</b>	
ADDRESS <b>Bethesda, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Frederick Lawler</b>	

RECEIVED

JUN 14 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6438

# CERTIFICATE OF DEATH

Reg. Dist. No.

06451

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>XXXXXX</b>	
c. LENGTH OF STAY IN 1b <b>83 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lausau Patient River</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>		d. STREET ADDRESS <b>523 Park Avenue</b> <b>MOG-938-B, U.S. Naval Air Station</b>	
3. NAME OF DECEASED (Type or print) First <b>Suann</b> Middle <b>Marie</b> Last <b>CRONK</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1957</b>
9. AGE (In years last birthday) <b>22</b>		10. IF UNDER 1 YEAR <b>2</b> Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert Ray CRONK</b>		14. MOTHER'S MAIDEN NAME <b>Carole KAAS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Robert R. CRONK (Father)</b>		Address <b>(Same as #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hydrocephalus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>X</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo 32 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 12</b> , 1957, to <b>June 3</b> , 1957, that I last saw the deceased alive on <b>June 3</b> , 1957, and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George J. A. Magnant</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>George J.A. MAGNANT, LT, MC, USN</b>		DATE SIGNED <b>6-4-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-7-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24. REC'D BY REGISTRAR <b>Mary E. Parrelly</b>	
ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>		DATE <b>6-5-57</b>	

BUREAU V. S.

JUN 6 1957

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06452

6489

CERTIFICATE OF DEATH

Reg. Dist. No.

246

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5218 Edgemoor Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Crosser</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-1874</u>
9 AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>26</u> IF UNDER 24 HRS: Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House of Representatives</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>	
11 BIRTHPLACE (State or foreign country) <u>U.S.</u>		12 CITIZEN OF WHAT COUNTRY? <u>yes</u>	
13. FATHER'S NAME <u>James Crosser</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Hogg</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Crosser</u> Address <u>5218 Edgemoor Lane Bethesda 14 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Decompensation and congestive heart failure</u> DUE TO (b) <u>auricular &amp; ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u>and myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u> 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-22-52</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec</u> 1956, to <u>3 June</u> 1957, that I last saw the deceased alive on <u>2 June</u> 1957, and that death occurred at <u>3:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>5029 Bethesda Ave.</u> DATE SIGNED <u>3 June 57</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>6/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highland Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cleveland, Ohio</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>6/4/57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Pumphrey</u>

BUREAU V. S.

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6439

## CERTIFICATE OF DEATH

06453

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>18-1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b>				c. LENGTH OF STAY IN 1b <b>4 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>6709 Gude Avenue</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park, Md.</b>			
f. STREET ADDRESS <b>6709 Gude Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Weston LeRoy</b> Middle <b>Cryer</b> Last <b>Cryer</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/13/1899</b>	9. AGE (In years last birthday) <b>58</b> yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Eng. Safeway Store</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Cryer</b>				14. MOTHER'S MAIDEN NAME <b>unobtainable -- Pittman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Betty Cryer 6709 Gude Ave., Takoma Pk, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension, old Cerebro-Vascular Accident 4 yrs.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County), (State)	
21. I certify that I attended the deceased from <b>April 26</b> , 19 <b>53</b> , to <b>June 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 1</b> , 19 <b>57</b> , and that death occurred at <b>7 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Ernest A. Sarao MD</b>				ADDRESS (Street, city or town, state) <b>7006 New Hampshire Ave</b>		DATE SIGNED <b>6/3/57</b>	
PHYSICIAN'S NAME (Type) <b>Ernest A. Sarao</b>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <b>6/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				ADDRESS <b>Wash, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUN 6 1957</b>	
				24b. REGISTRAR'S SIGNATURE			



RECEIVED

JUN 6 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06454

6490

## CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		c. LENGTH OF STAY IN 1b <b>5days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park</b>	
		d. STREET ADDRESS <b>4319 Van Buren Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Cumberland</b> Last <b>Maryland</b>		4. DATE OF DEATH Month <b>June</b> Day <b>12th</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 6th, 1866</b> 90 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William Thomas Cumberland</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bannister</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs John Orspada Same d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. p.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>June 11, 1957</b> to <b>June 12, 1957</b> , that I last saw the deceased alive on <b>June 11, 1957</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Kerr</b>		ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>		DATE SIGNED <b>6/12/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-15-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Mattingly</b>		24. REC'D BY REGISTRAR <b>131-1118</b>	
		24b. REGISTRAR'S SIGNATURE <b>14 1957</b>	

RECEIVED

JUN 14 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1SME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 06455									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seneca</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> 26			d. STREET ADDRESS <b>508 Denham Road</b> 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>William</b> Last <b>CURTIS, Jr.</b>					4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>19 57</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 20, 1942</b>		9. AGE (In years last birthday) <b>14</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>George W. Curtis, Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Mildred L. Harding</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Geo. W. Curtis, Sr. - Item # 2</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Drowning</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Drowned while swimming in Potomac River</b>							
20c. TIME OF INJURY Month, Day, Year Hour <b>1:10</b> <b>6/15/57</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Potomac river</b>		20f. (City or town) <b>Seneca</b>		20g. (County) <b>Montgomery</b>	
								20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>June 15, 1957</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Darnestown</b>			22d. LOCATION (City, town, or county) <b>Darnestown, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>					24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>June 19 1957</b>		

RECEIVED

JUN 19 1957

BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 15, 16 Film 0217 7-12-57 et

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>X2 Bethesda</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		d. STREET ADDRESS <b>7911 Kentbury Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>BARENT HOILES De NIKE</b>		4. DATE OF DEATH Month Day Year <b>June 17 19 57</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 26, 1936</b>		9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Mass.</b>				12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>J. Harold DeNike</b>				14. MOTHER'S MAIDEN NAME <b>Alice Hoiles</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Arry M6 Aug. '55-May '56</b>				16. SOCIAL SECURITY NO. <b>101-28-1738</b>				17. INFORMANT <b>Father- Item # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thoracic Hemorrhage</b> DUE TO <b>Crushed Chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Left Arm practically amputated at shoulder</b>												INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Arm practically amputated at shoulder</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Threw self in front of approaching Freight Train</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>B &amp; O R.R.</b>				20c. TIME OF INJURY Month, Day, Year <b>6/17/ 19 57</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bethesda, Montg. Co., Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>6/17/57</b>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Transit</b>				22b. DATE THEREOF <b>6/18/57</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Montrose</b>				22d. LOCATION (City, town, or county) (State) <b>Bond County, Illinois</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumpjirey- Bethesda, Md.</b>								ADDRESS <b>Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>6-24-57</b>				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED

JUN 26 1957

BUREAU V. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6133

## CERTIFICATE OF DEATH

06457  
27

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Langley Park - Silver Spring</u>			
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <u>Sharon Chronic Hospital</u>				d. STREET ADDRESS <u>7</u>			
3. NAME OF DECEASED (Type or print) First <u>Amanda</u> Middle <u>Dennis</u> Last <u>Dennis</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9 1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Rutland, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Thiele</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Blanker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(I yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Henry W. Stafford (son)</u> Address <u>5012 M... Ave Wash. D.C. NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>						<u>3 days</u>	
DUE TO <u>Cerebral Infarction</u>						<u>8 weeks</u>	
DUE TO <u>Hypertensive Cardiovascular Disease</u>						<u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>220x</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>June 8, 1957</u> , that I last saw the deceased alive on <u>June 8, 1957</u> , and that death occurred at <u>8:15</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabin</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1019 University Boulevard Silver Spring</u>			
PHYSICIAN'S NAME (Type) <u>BORIS RABIN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-11-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prompt Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. ...</u> ADDRESS <u>5406 ... Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>JUN 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	



Received from Mr. [unclear]  
 6-11-57

RECEIVED  
 6-11-57

JUN 14 1957

BUREAU V. S.

8  
 3 days  
 with the

Rutland, Iowa  
 Sept 2, 1957  
 Dennis  
 June 8

F White  
 Rutland  
 Sharon Chronic Hospital

3 days  
 Rutland  
 7  
 8  
 9

## 6494

## MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/55

BUREAU V. S.

JUN 10 1957

RECEIVED

6495

## CERTIFICATE OF DEATH

Reg. Dist. No.

064594

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Rural)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Road</u>				d. STREET ADDRESS <u>Fairland Road</u>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Poor</u> Middle <u>Poor</u> Last				4. DATE OF DEATH Month <u>6</u> - Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 5, 1881</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Fitzpatrick</u>				14. MOTHER'S MAIDEN NAME <u>Batherine Cullen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Catherine M. Ruppert</u> Address <u>Silver Spring Fairland Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> <u>4 days</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arthritis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>3/11</u> , 19 <u>58</u> , to <u>6/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/14</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Bird</u>				M.D. <u>Sandy K. P.</u> ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>MD 6/14/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Severs Sons Co</u>				ADDRESS <u>3605-14 St N W</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 18 1957  
BUREAU V. S.

6496  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wood Acres</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wood Acres</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5604 Gloster Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dwight</b> Middle <b>David</b> Last <b>Doty</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/10/1906</b>
9. AGE (In years lost birthday) yrs. <b>51</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Haley-Doty</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Doty</b>		14. MOTHER'S MAIDEN NAME <b>Rose Reid</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Dorothy V. Doty</b>		Address <b>Wood Acres, 5604 Gloster Road, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>42001</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis 3 yrs</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>43000</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 1942</b> to <b>June 5, 1957</b> , that I last saw the deceased alive on <b>June 5, 1957</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James T. Burns</b> M.D.		ADDRESS (Street, city or town, state) <b>915-19th ST. N.W.</b> DATE SIGNED <b>6/5/57</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. BURNS</b>		<b>Wash. D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/8/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>Wash. D.C.</b> 24b. REGISTRAR'S SIGNATURE <b>JUN 10 57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6497

## CERTIFICATE OF DEATH

06462

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>9 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>409 Silver Spring Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>S. Isaac Elder</b>				4. DATE OF DEATH <b>June 15</b> 19 <b>57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1869</b>		9. AGE (In years last birthday) <b>88</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ministry</b>		11. BIRTHPLACE (State or foreign country) <b>Knoxville, Iowa</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>S. Griffin Elder</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Ellen Brady</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Mrs. Florian J. Yeager, 409 Silver Spring Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory</b> DUE TO <b>Antibiotic renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 years</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5 June, 1957</b> to <b>15 June, 1957</b> , that I last saw the deceased alive on <b>15 June, 1957</b> , and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Seruch T. Kimble</b> M.D.				ADDRESS (Street, city or town, state) <b>929 Pershing Drive, Silver Spring, Md.</b> DATE SIGNED <b>6/16/57</b>			
PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit-Burial 6/19/57</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Werner E. Humphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6/17/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Teller</b>			



RECEIVED

JUN 19 1967

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06463

6498

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Montgomery</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Silver Spring</u>	<u>1 year</u>	TOWN <u>Silver Spring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3711 Randolph Rd.</u>		STREET ADDRESS (If rural give location) <u>3711 Randolph Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Oscar Maurice EISEN</u>		OF DEATH: <u>6 15 1957</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>5-7-14</u>
		9. AGE last birthday <u>43</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Contractor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Roofing Contractor</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Louis N. Eisen</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Edelman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT & ADDRESS: <u>2312 Washington Ave. David T. Eisen, Chevy Chase, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4 IMMEDIATE CAUSE (A) <u>coronary Thrombosis</u>			30 mins.
ANTECEDENT CAUSE (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19A. DATE OF OPERATION: _____		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>6/15/57</u> 19, to <u>6/15/57</u> 19, that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>4:20 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS <u>M.D. 2322 Bluebridge Ave., Silver Spring, Md.</u>	
DATE SIGNED _____			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>6/16/1957</u>	NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM. PARK</u>	LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>
DATE REC'D BY LOCAL REGISTRAR <u>6-17-57</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Home 4217-9-2 NW</u>	

RECEIVED

JUN 19 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6499

## CERTIFICATE OF DEATH

Reg. Dist. No.

06464

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 1/2 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>13202 Okinawa Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>ENNIS Grover Stevenson Ennis</b>				4. DATE OF DEATH <b>June 22 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/94</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dairy Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Prince William County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George T. Ennis</b>				14. MOTHER'S MAIDEN NAME <b>Roxy Randall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>229-34-3661</b>		17. INFORMANT <b>Lena Pearson</b> Address <b>13202 Okinawa Ave., Rockville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>6-22-57</b> , 19 <b>57</b> , to <b>6-22-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-22-57</b> , 19 <b>57</b> , and that death occurred at <b>4:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jason Geiger</b> M.D.				ADDRESS (Street, city or town, state) <b>931 Pershing Dr., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>JASON GEIGER</b>				DATE SIGNED <b>6-22-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>6-24-57</b>		24b. REGISTRAR'S SIGNATURE <b>Beanie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

UN 26 1957

JOHN V. B.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06465

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY in 1b <u>2 1/2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>800 Buckingham Drive</u>				d. STREET ADDRESS <u>129 Philadelphia Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VERNA</u> Middle <u>S.</u> Last <u>EVANS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>5</u> Min <u>7</u>	IF UNDER 24 HRS. Hours <u>5</u> Min <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Baldwin</u>				14. MOTHER'S MAIDEN NAME <u>Ada Farabee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Hazel Reng</u> Address <u>29 Philadelphia Ave T.P.M.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage - Right Hemisphere</u> <u>+ 40 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 weeks</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2:00 pm</u> , 1957, to <u>6:56 am</u> , 1957, that I last saw the deceased alive on <u>5 June</u> , 1957, and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>H. B. GILLEN</u> M.D. <u>7112 Willow Ave</u> <u>6 June</u> PHYSICIAN'S NAME (Type) <u>H. B. GILLEN</u> <u>Takoma Park Md</u> <u>1957</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>June 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Cornell Drive DC</u>		24a. REG. BY REGISTRAR <u>JUN 7 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Arthur Walters</u>			

RECEIVED

JUN 7 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6501

## CERTIFICATE OF DEATH

Reg. Dist. No.

06467  
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>5429 Connecticut Ave. NW. Wash DC</u> b. COUNTY <u>Wash DC</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Final Middle Last <u>Katie Fehér</u>				4. DATE OF DEATH <u>June 22</u> Month <u>22</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/17/82</u>	
9. AGE (In years, last birthday) <u>75</u> yrs		IF UNDER 1 YEAR: Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.		IF UNDER 24 HRS: Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Yugoslavia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Wm. Thomson, Room 808, Wash Press Bldg. Wash DC</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Interossealotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 YRS</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Pancreatitis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1952</u> to <u>June 22, 1957</u> , that I last saw the deceased alive on <u>June 21, 1957</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle</u>				DATE SIGNED <u>5009 Del Ray Ave, Bethesda, Md 20814</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT G ANGLE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-26-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>WEBSTER ST WASH DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>				ADDRESS <u>1400 Chapin St</u>		24a. REC'D BY REGISTRAR <u>JUN 25 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUN 25 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06468

## CERTIFICATE OF DEATH

Reg. Dist. No. 729

6440

1. PLACE OF DEATH Montgomery		2. USUAL RESIDENCE (HOME) OF DECEASED D. C.	
COUNTY	MARYLAND	STATE	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (If this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN	35 days	TOWN	Washington
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Santitarium Hosp		STREET ADDRESS 425 Butternut N. W.	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Bessie (First) Fenton (Middle) (Last)		June 1, 1957 (Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 8-1-70
9. AGE (last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov. Clerk	
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Fenton		14. MOTHER'S MAIDEN NAME Cordelia Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Hosp. Chart			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 74 x IMMEDIATE CAUSE (A) Carcinoma of Ovaries, with Metastasis ANTECEDENT CAUSE(S) DUE TO to colonand to retrogentoneal lymph nodes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) months			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 8, 1949, to June 1, 1957, that I last saw the deceased on May 31, 1957, and that death occurred at M from the causes and on the date stated above. SIGNATURE: [Signature] ADDRESS: 7835 Englewood Rd, June 2, 1957 M.D. [Signature]			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-4-57	
NAME OF CEMETERY OR CREMATORY Glenwood		LOCATION (City, town, or county) (State) Washington DC	
24. REC'D BY REGISTRAR JUN 5 1957		25. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home 4812 Ga. Ave. N. W. Wash. D. C.	

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

BUREAU V. S.

JUN 6 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.8

06469

1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>			
c. LENGTH OF STAY IN 1b <b>4 Yrs</b>				d. STREET ADDRESS <b>105 Tulip Drive</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>June</b> Middle <b>Pauline</b> Last <b>Filsinger</b>				4. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14-1927</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>29</b> Hours <b>Min.</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautytition</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Beauty Salon</b>		11. BIRTHPLACE (State or foreign country) <b>Zihlman, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Abram Windfield</b>				14. MOTHER'S MAIDEN NAME <b>Marion Downton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>George E Filsinger, Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asthma, Bronchial</b> DUE TO <b>Acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>June 12, 1957</b> to <b>June 13, 1957</b> , that I last saw the deceased alive on <b>June 12, 1957</b> , and that death occurred at <b>2:15 P. M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>26 N. Summit Ave. Gaithersburg, Md.</b> DATE SIGNED <b>6-14-57</b>							
ACTUAL SIGNATURE <b>Jack Summacher</b>				PHYSICIAN'S NAME (Type) <b>Southemby, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Eckhard</b>		22d. LOCATION (City, town, or county) <b>Eckhard Maryland</b> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hafer Funeral Home, Frostburg, Md.</b> ADDRESS _____				24a. REC'D BY REGISTRAR <b>June 15-57</b>		24b. REGISTRAR'S SIGNATURE <b>Abner L. Cooke</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 19 1957

BUREAU V. S.

6441

## CERTIFICATE OF DEATH

06470

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				e. STREET ADDRESS <u>7209 Flower Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>Ford</u> Last <u>Ford</u>				4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>girl</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/6/57</u>	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Min <u>39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME <u>Charles Theodore Ford</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Jean Dentith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>mother</u>		Address <u>as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal hydrocephalus</u> DUE TO <u>Betal malformation of the Brainstem?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ascites - cirrhosis of liver</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o</u> m <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/6</u> , 19 <u>57</u> , to <u>6/6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/6/57</u> , 19 <u>57</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9820 Dameran Dr. Silver Spring Md.</u> DATE SIGNED <u>---</u>							
ACTUAL SIGNATURE <u>D.A. St. Martin</u>				PHYSICIAN'S NAME (Type) <u>D.A. St. Martin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. &amp; Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park 12, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Farley, Jr.</u> ADDRESS <u>Wash. San. &amp; Hospital, Takoma Park</u>				24a. REC'D BY REGISTRAR <u>6/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 21 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

06471

6513

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>31 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
f. STREET ADDRESS <b>10306 Insley Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>Arturo Vazquez Fourzan</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1957</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 1, 1955</b>		9. AGE (In years last birthday) <b>one</b> yrs	F UNDER 1 YEAR IF UNDER 24 HRS Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>Mexico</b>		12. CITIZEN OF WHAT COUNTRY? <b>Mexico</b>	
13 FATHER'S NAME <b>Oswaldo Fourzan</b>				14 MOTHER'S MAIDEN NAME <b>Theresa Vazquez</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>		17 INFORMATION <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Insufficiency</b> DUE TO <b>Pulmonary effusions; inflammations, etc. Organomegaly</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Leukemia</b> DUE TO <b>Leukemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5321</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 weeks</b> <b>7 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 20, 1957</b> to <b>June 20, 1957</b> , that I last saw the deceased alive on <b>June 20, 1957</b> , and that death occurred at <b>4:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>William J. Pieper</b>				DATE SIGNED <b>6/20/57</b>			
PHYSICIAN'S NAME (Type) <b>William J. Pieper, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Panteon Jardin</b>		22d. LOCATION (City, town or county) (State) <b>Mexico City, Mexico</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				ADDRESS <b>2901 14th St., N.W.</b> <b>Washington 9, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUN 21 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11

SERVICIO EXTERIOR MEXICANO

No. -5- Derechos 50.00 M.N. \$15.4.00

CERTIFICO: que el Sr. William J. Pieper  
Médico Cirujano del Hospital  
Naval de Bethesda, Estado de Maryland,

es la autoridad competente para expedir  
el certificado que antecede

Washington, D. C. Junio 20 de 1957

P. O. del Embajador

*R. W. P. G.*

BUREAU V. S.

JUN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6544

CERTIFICATE OF DEATH

06472  
215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>26 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>4215 12th Road South</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Virginia</b> Last <b>FOX</b>				4. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1909</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Richard Henry YOUNG</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth WAGNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Husband, Wilmer Leroy FOX (Same as #2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>592 x DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>Chronic Glomerular Nephritis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>20+ yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 23, 1957</b> to <b>June 18, 1957</b> , that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>3:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 6-18-57</b>							
ACTUAL SIGNATURE <b>T.S. DUNN, Jr.</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md. 6-18-57</b>			
PHYSICIAN'S NAME (Type) <b>T.S. DUNN, Jr., LT MC USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b>				24a. REC'D BY REGISTRAR <b>6-18-57</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. A.

1957

RECEIVED

65-15  
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fredericksburg</b>	
3. NAME OF DECEASED (Type or print) First <b>Bradford</b> Middle <b>Daniel</b> Last <b>FRANZMAN</b>		d. STREET ADDRESS <b>1400 Kenmore Avenue</b>	
4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1957</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1957</b>
9. AGE (In years last birthday) yrs <b>0</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>August Daniel FRANZMAN</b>		14. MOTHER'S MAIDEN NAME <b>Catherine STAIR</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Father, August D. FRANZMAN (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>KIDNEY TUBES</b> <b>770.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>June 7, 1957</b> to <b>June 9, 1957</b> , that I last saw the deceased alive on <b>June 9, 1957</b> , and that death occurred at <b>5:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <b>Daniel Shuptar</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b> <b>6-10-57</b>	
PHYSICIAN'S NAME (Type) <b>Daniel SHUPTAR, LT, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-13-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Private Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Evansville, Indiana</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey, 7557 Wisc. Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-10-57</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 11 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

06474

214

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>CARROLL HALL Sanitarium</b>		e. STREET ADDRESS <b>1228 Eye St. N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>MYRTLE</b> Middle <b>S.</b> Last <b>GABLE</b>		4. DATE OF DEATH Month <b>6</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 11-1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter E. Slaughter</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET Hays</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>son</b>		Address <b>Lewis M. Gable 1225 Park Ave..N.Y.,N.Y.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>201X GENERALIZED ARTERIOSCLEROSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **MAY 13, 1956**, to **6-25, 1957**, that I last saw the deceased alive on **6-25, 1957**, and that death occurred at **1:15A** M, from the causes and on the date stated above.

ACTUAL SIGNATURE <i>[Signature]</i>	M.D. <b>5206 Norway Dr.</b>	DATE SIGNED <b>Chen-chue, Wu</b>
PHYSICIAN'S NAME (Type)		

22a. BURIAL OR CREMATION REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>6/26/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wagner Asso. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Wagner, S. D.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b>	ADDRESS <b>Wash, D.C.</b>	24a. REC'D BY REGISTRAR <b>JUN 27 1957</b>	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 27 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06475

6517

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14, Maryland</b>		c. LENGTH OF STAY IN 1b <b>53 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 471</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			d. STREET ADDRESS <b>3612 Park Place, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>(No Middle Name)</b> Last <b>Gabriel</b>			4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>19 57</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 27, 1909</b>		9. AGE (In years last birthday) <b>47</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Frank Gabriel</b>			14. MOTHER'S MAIDEN NAME <b>Agnes Knox</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>Not available</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>1x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic uremia</b> DUE TO (c) <b>Complication of the uremic state</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Three weeks</b> <b>at least 2 1/2 weeks</b> <b>One year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>April 17</b> , 19 <b>57</b> , to <b>June 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 9</b> , 19 <b>57</b> , and that death occurred at <b>6:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b> DATE SIGNED <b>6/10/57</b> SIGNATURE <b>Martin E. Liebling, M.D.</b> M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>6/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM</b>	22d. LOCATION (City, town, or county) (State) <b>MARYLAND</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Angela Funeral Home</b>		24a. REC'D BY REGISTRAR <b>389 R. 4 Avenue</b>	24b. REGISTRAR'S SIGNATURE <b>Periss...</b>		



RECEIVED

JUN 12 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06476  
214

Reg. Dist. No.

6508

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>MONTGOMERY</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rear of Fred &amp; Harry's Restaurant</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>			
f. STREET ADDRESS <b>104 Williamsburg Drive</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROLAND</b> Middle <b>WILLIS</b> Last <b>GARNER</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/6/98</b>		9. AGE (In years last birthday) <b>58</b> yrs.	10. UNDER 1 YEAR Months <b>58</b> Days <b>58</b>	11. UNDER 24 HRS. Hours <b>58</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER and Bus Driver Instructor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIS H. GARNER</b>				14. MOTHER'S MAIDEN NAME <b>MELVIN WINDSTEAD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW #1 578-10-5567</b>		17. INFORMANT <b>Mrs. Ellen C. Wolfhope, 104 Williamsburg Drive Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> <b>782.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>630 57</b>		24b. REGISTRAR'S SIGNATURE <b>Stanley Carter</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be completed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06477

6599

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>Silver Spring</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d STREET ADDRESS <b>8101 Piney Branch Road</b>			
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last <b>Ivie Carole Barr GRAEVES</b>				4. DATE OF DEATH Month Day Year <b>June 26 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 28 1940</b>	
9. AGE (In years last birthday) yrs. <b>16</b>		IF UNDER 1 YEAR Months Days Hours Min <b>16</b>		IF UNDER 24 HRS.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Raymond B Graeves</b>				14. MOTHER'S MAIDEN NAME <b>Vivian Allie Barr McGinn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Col Raymond B Graeves - 8101 Piney Br Silver Spring</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ependymoma 4th ventricle with metastasis to subarachnoid</b> DUE TO (b) <b>193X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>to subarachnoid</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 1952</b> , 19 <b>57</b> , to <b>June 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>18 June</b> , 19 <b>57</b> , and that death occurred at <b>12:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6/26/57</b> DATE SIGNED <b>Med Cert of Reg 4906, 20 Mar 44</b> ACTUAL SIGNATURE <b>George J. Hayes</b> M.D. PHYSICIAN'S NAME (Type) <b>George J Hayes</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>							
22b. DATE THEREOF <b>6/28/57</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>GEO. WASH. MEM. CEMETERY</b>							
22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MD.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>							
24a. REC'D BY REGISTRAR <b>6/30/57</b>							
24b. REGISTRAR'S SIGNATURE <b>Frances J. [illegible]</b>							

S. A. L.

250

DEAD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06478

218

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home for the Aged, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u> First Middle Last <u>GRAF</u>		4. DATE OF DEATH <u>JUNE</u> Month <u>14</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1871</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Sebastian Rockensuess</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bartman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Asbury Methodist Home, Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>cardiovascular disease hypertrophied heart</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>551X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-11</u> , 19 <u>56</u> , to <u>6-14</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 12</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Sarah Elizabeth Glover</u> M.D. <u>4208 Anthony ST. Kensington Md 6-14-57</u> PHYSICIAN'S NAME (Type) <u>Sarah Elizabeth Glover</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Com.</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Dickner &amp; Sons - Baltimore</u>		24a. REC'D BY REGISTRAR <u>no</u>	24b. REGISTRAR'S SIGNATURE <u>Alvin B. Cook</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 21 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 26 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07613

Reg. Dist. No. 214

6511

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>6 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				d. STREET ADDRESS <u>3000 "McComas Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ned</u> First <u>Merrill</u> Middle <u>Green</u> Last				<b>4. DATE OF DEATH</b> <u>6/20/57</u> Month Day Year			
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5/10/1897</u>			
<b>9. AGE</b> (In years last birthday) <u>60</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Col</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Army retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Tan.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>"SA</u>				<b>13. FATHER'S NAME</b> <u>Abemiah Green</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Sturtevant</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W W I</u>			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>San. Records</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>782.4</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            DUE TO <u>Acute Cardiac Failure</u> </div> <div style="width: 35%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>one day</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>6/29/57</u>			
<b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>7/2/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>			
<b>22d. LOCATION</b> (City, town, or county)		<b>(State)</b> <u>Arlington Virginia</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph Benbow's Son</u>		<b>ADDRESS</b> <u>1756, Pennsylvania Ave Washington, DC</u>		<b>24a. REC'D BY REGISTRAR</b> <u>7/5/57</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Frances Potter</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

1917

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## CERTIFICATE OF DEATH

Reg. Dist. No. 215

06479

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Chevy Chase</b>	
d. STREET ADDRESS <b>3603 Dunlop Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Miller</b> Last <b>GREENLEE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-19-84</b>
9. AGE (in years last birthday) <b>72</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>4</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Miller</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Farris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Daughter, Mrs. Elizabeth Oehmann (Same As #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Anasarcia</b> DUE TO <b>Hypoalbuminemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis, cause unknown</b> DUE TO (c) <b>15 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6 May</b> , 19 <b>57</b> , to <b>4 June</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3 June</b> , 19 <b>57</b> , and that death occurred at <b>4:25 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. U. Shilling</b> M.D.		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>6-4-57</b>	
PHYSICIAN'S NAME (Type) <b>Charles U. SHILLING, DT (MC) USN/U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-7-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>6-4-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Farrelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 6 1957

RECEIVED

6442

## CERTIFICATE OF DEATH

Reg. Dist. No.

1773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmersville, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>12134 Viers Mill Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Guthrie</u>				4. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Boy</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-10-57</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Charles Marsh Guthrie</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Stephanie Steady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>M. Locke, R.N.</u> Address <u>Washington Sanitarium</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythema Nodosum Fekete</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 10, 1957</u> to <u>June 10, 1957</u> , that I last saw the deceased alive on <u>June 10, 1957</u> , and that death occurred at <u>7:10 AM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Michael M. Dobridge</u>				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave. Silver Spring, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Michael M. Dobridge, M. D.</u>				10620 Georgia Avenue, Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-12-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon - 3831 - GA. Ave. N.W.</u>				24. REC'D BY REGISTRAR <u>J. H. H. H. H.</u>			
25. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 17 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6513

## CERTIFICATE OF DEATH

Reg. Dist. No.

06481

217

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Austin Warner Hammond</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 57</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/13/98</b>	9. AGE (In years last birthday) <b>59 yrs</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>9</b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Government Employee</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		
					12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		
13. FATHER'S NAME <b>Otho Warner Hammond</b>				14. MOTHER'S MAIDEN NAME <b>Lula Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic cardiovascular disease</b> <b>415X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 10, 1951</b> to <b>June 20, 1957</b> , that I last saw the deceased alive on <b>June 22, 1957</b> , and that death occurred at <b>4:45 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James P. Kerr</b> M.D.				ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		DATE SIGNED <b>6-22-57</b>	
PHYSICIAN'S NAME (Type) <b>J. P. Kerr, M. D.</b>				ADDRESS <b>Damascus, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Clarksburg Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>JUN 24 1957</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6514

## CERTIFICATE OF DEATH

06482

Reg. Dist. No. 218

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown Rural</u>			
c. LENGTH OF STAY IN 1b <u>85 yrs</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Nicholas</u> Middle <u>Harding</u> Last <u>Harding</u>			4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1957</u>				
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1872</u>		9. AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Letter Mail Co.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Harding</u>			14. MOTHER'S MAIDEN NAME <u>Ann Beavell</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Joseph E. Koch</u> Address <u>4105 Harrison St. Baltimore, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb.</u> , 1957, to <u>June 22</u> , 1957, that I last saw the deceased alive on <u>June 22</u> , 1957, and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vernon E. Martens</u> M.D.			ADDRESS (Street, city or town, state) <u>Germanstown, Md.</u> DATE SIGNED <u>6-22-57</u>				
INTERPRETER'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Emmet C. Goffman</u>			ADDRESS <u>Gaithersburg Md.</u>		24a. REC'D BY REGISTRAR <u>June 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Abraham G. Cooke</u>



RECEIVED

JUN 28 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6515  
CERTIFICATE OF DEATH

Reg. Dist. No. 214

06453

1. PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Res. dence before admission) a STATE MARYLAND b COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2700 HARDY AVENUE		d STREET ADDRESS 2700 HARDY AVENUE	
3. NAME OF DECEASED (Type or print) First MARY Middle EDNA Last HARDY		4. DATE OF DEATH Month JUNE Day 17 Year 57	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/76
9 AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK - Bureau of Engraving - U.S. Gov't.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. FRANCIS HARDY		14. MOTHER'S MAIDEN NAME Mary E. Sheehy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Beulah A. Clarke, 2700 Hardy Ave.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) a metastases DUE TO abdomen (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5, 1956, to June 14, 1957, that I last saw the deceased alive on June 17, 1957, and that death occurred at 5:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Patrick Jameson M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 12020 Georgia 6/17/57	
PHYSICIAN'S NAME (Type) PATRICK JAMESON		Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/20/57	
22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE William E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 6/20/57		24b. REGISTRAR'S SIGNATURE Francis J. Miller	

RECEIVED

JUN 14 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6516

## CERTIFICATE OF DEATH

06484

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JONATHAN WATERS HASLUP</u>		4. DATE OF DEATH Month Day Year <u>JUNE 24 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC-5-1892</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONTRACTOR</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GILBERT A. HASLUP</u>		14. MOTHER'S MAIDEN NAME <u>ANNA TURNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>SISTER</u> Address <u>MRS DOROTHY STACK HOUSE 3701 CONN.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bronchopneumonia</u> DUE TO <u>Ch. Pulmonary Emphysema</u> DUE TO <u>Ch. Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>10 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-12-57</u> to <u>6-24-57</u> , that I last saw the deceased alive on <u>6-23-57</u> , 19 <u>57</u> , and that death occurred at <u>12:05 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew J. Betz</u> M.D.		ADDRESS (Street, city or town, state) <u>5412 Colo Ave N.W. Washington D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Andrew J. Betz</u>		DATE SIGNED <u>6-24-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>25 1957</u> 24b. REGISTRAR'S SIGNATURE <u>John Thompson</u>	

BUREAU V. S.

JUN 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 10 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Fill pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6517

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06485

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>Washington, D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>435 Northwest Drive</u>		d. STREET ADDRESS <u>4801 Connecticut Avenue, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert E. Heater</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/75</u>
9. AGE (In years to birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John P. Heater</u>	
14. MOTHER'S MAIDEN NAME <u>Matilda Wire</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Evelyn S. Heater, 4801 Conn. Ave., N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage &amp; laceration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound through skull</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Self inflicted bullet wound</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:25</u> a. m. <u>6/16</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Office</u>		20f. (City or town) (County) (State) <u>Silver Spring, Montgomery, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>June 16, 1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Potts</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>6/20/57</u>		24b. REGISTRAR'S SIGNATURE <u>Francis J. Potts</u>	

RECEIVED

JUN 21 1957

BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6518 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06486  
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4400 Glen Ridge Rd</u>				d. STREET ADDRESS <u>4400 Glen Ridge Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Clode</u> Last <u>Heflin Jr</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8 1918</u>	
9. AGE (in years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>24</u>		IF UNDER 24 HRS. Hours <u>24</u> Min <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>sales manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Refrigeration co</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Louise C Heflin</u>				14. MOTHER'S MAIDEN NAME <u>Indelstra White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>577-16-4607</u>		17. INFORMANT <u>Shirley Heflin</u> Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>Ecdema of larynx</u> DUE TO (c) <u>Fulminating Bacterial Infection</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>54X</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>1 hour</u> <u>few hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>54X</u> <u>Systema Sinus</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>6/4/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial/cremation, or removal.



BUREAU V. S.

JUN 2 1917

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06487

6519

## CERTIFICATE OF DEATH

Reg. Dist. No. 2116

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Dist. of Col.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>5407 41st St., N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Bell</b> Last <b>Henry</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 23, 1889</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>19</b> Min <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Admin. Assistant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Interior</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joseph P. Fincham</b>				14. MOTHER'S MAIDEN NAME <b>Lillie Mitchell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Edith Henry Tufty</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>465x Pulmonary Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple pulmonary emboli</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>153x Metastatic Carcinoma from Carcinoma of Colon</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>Dec.</b> , 19 <b>56</b> , to <b>6-9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-9</b> , 19 <b>57</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Russell M. Tilly, Jr.</b>				ADDRESS (Street, city or town, state) <b>4201 - Mass Ave. N.W. Wash. D.C.</b>			
DATE SIGNED <b>6-18-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				22b. DATE THEREOF <b>6/12/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	
22d. LOCATION (City, town, or county) <b>Washington D.C.</b>				(State) <b>D.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clayton Charles Funeral Home D.C.</b>				ADDRESS <b>4201 - Mass Ave. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 6-18-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>							

RECEIVED

JUN 19 1957

BUREAU V. M.

6443

## CERTIFICATE OF DEATH

064883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. &amp; Hosp</u>		d. STREET ADDRESS <u>911 Ray Rd. N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Elizabeth</u> Last <u>Herder</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-81</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Don't employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Don't employee</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>William Hall</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Beach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Chart</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>3IX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Acute.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>July</u> 19 <u>56</u> , to <u>June</u> 18, 19 <u>57</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>57</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above					
ADDRESS (Street, city or town, state)			DATE SIGNED		
ACTUAL SIGNATURE <u>Ernest A. Sarno M.D.</u>			<u>7006 NEW HAMPSHIRE Ave 6/18/57</u>		
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARNO</u>			<u>Takoma Park 12, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)		
<u>BURIAL</u>	<u>6/21/1957</u>	<u>CEDAR HILL CEM.</u>	<u>SUITLAND R R 600 Co, MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE			24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE		
<u>W.W. Chambers Co. (Baltimore Ave. Md.)</u>			<u>June 24 1957</u>		

THE HEALTH OFFICER OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 72 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 6520  
 CERTIFICATE OF DEATH

06489

Reg. Dist. No.

212

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>Protesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Rural</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Marshall</u> First Middle <u>Hersberger</u> Last				4. DATE OF DEATH <u>June - 23 - 1957</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March - 22 - 1880</u> 9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Protesville, Montg Co, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aaron Bucher Hersberger</u>				14. MOTHER'S MAIDEN NAME <u>Edna Earle Hersberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edna Earle Hersberger</u> Address <u>Protesville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>23</u>	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>May - 23 - 1957</u> , to <u>June - 23 - 1957</u> , that I last saw the deceased alive on <u>June - 23 - 1957</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.				ADDRESS (Street, city or town, state) <u>7-Brooks Ave., Gaithersburg, Md.</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Protesville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u> ADDRESS <u>Barnesville, Md</u>				24a. REC'D BY REGISTRAR <u>Charles W. Elgin</u> DATE <u>6/25/57</u>		24b. REGISTRAR'S SIGNATURE <u>per 582</u>	

MEDICAL CERTIFICATION

RECEIVED

JUN 27 1957

BUREAU V. 3

6521

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admssion) b. STATE <b>D C</b> c. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>2335 California St NW</b>	
3. NAME OF DECEASED (Type or print) First <b>EMELEEN</b> Middle <b>CARLISLE</b> Last <b>HILL</b>		4. DATE DEATH <b>June</b> Month <b>24</b> Day <b>1957</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1876</b> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Carlisle</b>		14. MOTHER'S MAIDEN NAME <b>Emeline Howe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Marianna H. deBeers, 2335 Calif. St NW</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon &amp; metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 17, 1957</b> , to <b>June 24, 1957</b> , that I last saw the deceased alive on <b>June 17, 1957</b> , and that death occurred at <b>3:00 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. D. Bonifant</b> M.D.		ADDRESS (Street, city or town, state) <b>Sandy Spring Md</b> DATE SIGNED <b>6/24/57</b>	
PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT</b>		<b>Sandy Spring Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>6/26/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Bonifant</b>		24a. REC'D BY REGISTRAR <b>DATE 6/26/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Laurel Keaton</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUN 29 1917

RECEIVED

6522

## CERTIFICATE OF DEATH

06491

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Garden Sanatorium</u>				d. STREET ADDRESS <u>2800 Quebec St. NW</u>			
3. NAME OF DECEASED (Type or print) <u>PAUL</u> First <u>E.</u> Middle <u>Huettner</u> Last				4. DATE OF DEATH <u>June 18 1957</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-1870</u>	
9. AGE (In years last birthday) <u>87</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov. Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Huettner</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Louise C. Hagen Daughter</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>122.1</u> DUE TO <u>Branchiopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>A.S.C.U.D.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>12 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Jan 1957</u> to <u>6/18 1957</u> , that I last saw the deceased alive on <u>6/18 1957</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles M. Weber</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL (CREMATION, REMOVAL) (Specify)		22b. DATE THEREOF <u>6/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>J. Wm. Lees</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lees</u> ADDRESS <u>300 - 4 ST NE</u>				24a. REC'D BY REGISTRAR DATE <u>6-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED

JUN 26 1957

RECEIVED

6523

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>West Virginia</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN 1b <b>11 days</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg</b>	
f STREET ADDRESS <b>211 Rockwell Avenue</b>		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Larry Eugene Hughes</b>		4. DATE OF DEATH Month Day Year <b>June 25 1957</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 24, 1942</b>
9 AGE (In years last birthday) <b>15 yrs</b>		F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Stacey Hughes</b>		14 MOTHER'S MAIDEN NAME <b>Pearl Bivins</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Test no. or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>204.5 pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Valerian</b> DUE TO (c) <b>acute leukemia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>3 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>D</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>G</b>	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>G</b>	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 14, 1957</b> , to <b>June 25, 1957</b> , that I last saw the deceased alive on <b>25 June, 1957</b> , and that death occurred at <b>12:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas Waldmann</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
DATE SIGNED <b>6/26/57</b>			
PHYSICIAN'S NAME (Type) <b>Thomas Waldmann, M. D.</b>			
22a BURIAL, CREMATION, RE MOVAL (Specify) <b>Burial</b>	22b DATE THEREOF <b>6/28/57</b>	22c NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>	22d LOCATION (City, town, or county) (State) <b>Martinsburg, W. Va.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		ADDRESS <b>24a REC'D BY REGISTRAR</b> <b>DATE 6-27-57</b>	
		24b REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 2

1000 1 100

RECEIVED

6444

## CERTIFICATE OF DEATH

Reg. Dist. No.

773

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <b>D.C.</b> b. COLN ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK.</b>		c. LENGTH OF STAY IN 1b <b>2 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>OAKHAVEN CONV. HOME.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
3. NAME OF DECEASED (Type or print) <b>Willis F. HURD</b>		4. DATE OF DEATH <b>June 17 1957</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/26/69</b>
9. AGE (In years last birthday) <b>88</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - exec SOUTHERN RLVY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Georgia</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Levi J. HURD</b>		14. MOTHER'S MAIDEN NAME <b>Letitia Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>718-10-5943</b> 17. INFORMANT <b>Willis L. Hurd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerosis, generalized,</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		19. INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JULY 9, 1954</b> to <b>JUNE 17, 1957</b> , that I last saw the deceased alive on <b>JUNE 16, 1957</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William F. Simpson, Jr.</b>		DATE SIGNED <b>6/17/57</b>	
PHYSICIAN'S NAME (Type) <b>William F. Simpson, Jr.</b>		ADDRESS (Street, city or town, state) <b>6216 N.H. Ave. N.E. Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24. REC'D BY REGISTRAR <b>JUN 19 1957</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 19 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6445

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06494

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 Takoma Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6613 Allegheny Ave.</b>				d. STREET ADDRESS <b>6613 Alle gheny Ave</b>		e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>Wilhelm</b> Last <b>ISAACSON</b>				4. DATE OF DEATH <b>6/28/57</b> Month Day Year			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/1886</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>		11. BIRTHPLACE (State or foreign country) <b>Sweeden</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Isaacson</b>				14. MOTHER'S MAIDEN NAME <b>Not Available</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Uma S. Isaacson</b> Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit Burial</b>		22b. DATE THEREOF <b>7/3/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cherry, Minnesota</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b>				ADDRESS <b>254 Canoe Dr. N.W. Wash D.C.</b>		24a. REC'D BY REGISTRAR <b>7/1/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>J. William Lodd</b>	

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MEDICAL CERTIFICATION



U.S. A.

1957

DEAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6524

## CERTIFICATE OF DEATH

Reg. Dist. No.

06495

1 PLACE OF DEATH a COUNTY <u>MONTG</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3460 39th St., N.W.</u>	
3 NAME OF DECEASED (Type or print) First <u>CLARENCE</u> Middle <u>H.</u> Last <u>Jewell</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1957</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-20-94</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Matre de</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Navy Club</u>	
11 BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Judson Jewell</u>		14. MOTHER'S MAIDEN NAME <u>EMROTTA GRIZZIN</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT <u>Hospt Record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute coronary occlusion</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-2-1957</u> to <u>6-5-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-5-1957</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>C. Roger Kurtz</u> M.D.		ADDRESS (Street, city or town, state) <u>3701 Greenhoe, W.</u>	
DATE SIGNED <u>6-5-57</u>			
PHYSICIAN'S NAME (Type) <u>C. Roger Kurtz</u>			
22a. BURIAL, CREMATION, or OTHER DISPOSITION (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax Co., Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		ADDRESS <u>Wash, D.C.</u>	
24a REC'D BY REGISTRAR DATE <u>6/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah Thompson</u>	

BUREAU V. B.

JUN 11 1957

RECEIVED

6525

## CERTIFICATE OF DEATH

Reg. Dist. No

06496

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		MARYLAND 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>Clarkston</b>	
c. LENGTH OF STAY IN 1b <b>301 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarkston</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b> <b>National Institutes of Health, Bethesda, Md.</b>		d. STREET ADDRESS <b>Route #1, Box 1-F</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>(No middle name)</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3 April 1911</b>
9. AGE (In years lost birthday) <b>46</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Public Health Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (State or foreign country) <b>Idaho</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul W. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Lura Burdick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO <b>574-10-2853</b>	
17. INFORMANT <b>The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> DUE TO <b>OX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma of Breast</b> DUE TO (c) <b>Metastatic Carcinoma of Breast</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (c) <b>Metastatic Carcinoma of Breast</b>			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 3, 1956</b> to <b>June 3, 1957</b> , that I last saw the deceased alive on <b>June 3, 1957</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b> DATE SIGNED <b>6/4/57</b>			
ACTUAL SIGNATURE <b>Arthur J. Garceau</b> PHYSICIAN'S NAME (Type) <b>Arthur J. Garceau, M. D.</b>		M.D. <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>6/5/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Vineland, Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Clarkston, Washington</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>6-6-57</b> 24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director and completely filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

JUN 10 1957

RECEIVED

6526

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		d. STREET ADDRESS <u>19412 Flower Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9412 Flower Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Tabitha</u> Last <u>Johnston</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>18 Sept 1906</u>
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u> IF UNDER 24 HRS: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher - Northwood &amp; Blair High School</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Herbert A. Johnston</u>	
14. MOTHER'S MAIDEN NAME <u>Bessie T. Schroyer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>  </u>	
16. SOCIAL SECURITY NO. <u>199-20-2781</u>		17. INFORMANT <u>H. A. Johnston</u> Address <u>9412 Flower Ave. S. Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Coronary Artery Sclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u> <u>1 yr</u> <u>4-5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity &amp; hypercholesterolemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 1954</u> to <u>29 June 1957</u> , that I last saw the deceased alive on <u>25 June 1957</u> , and that death occurred at <u>10:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u> M.D. <u>11134 Georgia Ave S.W. 29 June 57</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. MEM. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>7-3-57</u>
		24b. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAU V. B.

3 1957

RECEIVED

6527

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>33 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				d. STREET ADDRESS <b>9501 Colesville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Lester</b>		First <b>Earl</b>		Last <b>Jones</b>		4. DATE OF DEATH Month <b>June</b>	
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>14 May 1892</b>	
9. AGE (In years last birthday) <b>65</b>		IF UNDER 1 YEAR Months <b>6</b>		IF UNDER 24 HRS Days <b>2</b>		Hours <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Jones</b>				14 MOTHER'S MAIDEN NAME <b>Gertie Mertz</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>578-26-2846</b>		17 INFORMANT <b>The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>massive intrapulmonary hemorrhage &amp; edema</b> <b>4.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>acute myelogenous leukemia</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>May 13, 1957</b> , to <b>June 2, 1957</b> , that I last saw the deceased alive on <b>June 2, 1957</b> , and that death occurred at <b>12:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
SIGNATURE <b>William J. Pieper</b> M.D.				The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) <b>William J. Pieper, M.D.</b>							
22a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b DATE THEREOF <b>JUNE 5-1957</b>		22c NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>BOONSBORO WASH. CO. MD.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>BAST FUNERAL HOME</b>				ADDRESS <b>BOONSBORO MD</b>		24a REC'D BY REGISTRAR <b>5 1957</b>	
				24b REGISTRAR'S SIGNATURE <b>Thos. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
JUN 5 1957  
BUREAU V. S.

6528

## CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4918 Aurora Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cornelia</b> Middle <b>R.</b> Last <b>JOYCE</b>				4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/20/1892</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William C. Roberts</b>				14. MOTHER'S MAIDEN NAME <b>Jane A. Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Francis J. Manning</b> Address <b>4918 Aurora Drive Kensington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Apoplexy</b> DUE TO <b>Longstanding Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4.1</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>5/15/57</b> , 19 <b>57</b> , to <b>6/5/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/5/57</b> , 19 <b>57</b> , and that death occurred at <b>4:00</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Kensington, Md.</b> DATE SIGNED <b>6/5/57</b>							
ACTUAL SIGNATURE <b>Samuel Allen</b> M.D.				PHYSICIAN'S NAME (Type) <b>SAMUEL ALLEN</b> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.-2901 14th St., N.W.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 10 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Ernest A. King</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 4

JUN 10 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6529

## CERTIFICATE OF DEATH

06500

Reg. Dist. No. 212

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Slidell</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>(Oliver)</b> First <b>GARFIELD</b> Middle <b>KEITH</b> Last				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 10, 1880</b>	
9. AGE (In years lost birthday) <b>76</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Nathen Keith</b>				14. MOTHER'S MAIDEN NAME <b>Unk rown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Mrs. Laura E. Keith</b>		Address <b>Boyd's #2, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malnutrition</b> DUE TO (c) <b>Secondary anemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>6 months.</b> <b>6 months.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic hypertrophy</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 15</b> , 19 <b>53</b> , to <b>4 June</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>3 June</b> , 19 <b>57</b> , and that death occurred at <b>9 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Darmanville P.O. Boyd</b> DATE SIGNED <b>6/4/57</b>							
ACTUAL SIGNATURE <b>John G. Fawcett</b> M.D.				PHYSICIAN'S NAME (Type) <b>John G. Fawcett M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 7, '57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hyattstown Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond Barber</b>				ADDRESS <b>Saytonville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6/7/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles W. Elgin</b>			

RECEIVED

JUN 10 1957

BUREAU V. S.

6530

CERTIFICATE OF DEATH

06501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		d. STREET ADDRESS <b>3255 Patterson St., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Fannie</b> First Middle Last		4. DATE OF DEATH <b>June 18 1957</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 16, 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Pauline Long</b> Address <b>N.W. Ch. Ch., D.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Uremia</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
(b) <b>Nephrosclerosis</b> DUE TO		
(c) <b>Hypertensive Cardio-Vascular-Renal Disease</b> DUE TO		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Syns.</b>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **1956** to **June 18, 1957**, that I last saw the deceased alive on **June 17, 1957**, and that death occurred at **4:05 AM**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **3921 Ingoman St. N.W. Wash 15 D.C.** DATE SIGNED **6-18-57**

ACTUAL SIGNATURE **Stewart Clapp** M.D. PHYSICIAN'S NAME (Type) **Stewart Clapp**

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/20/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>	24a. REC'D BY REGISTRAR <b>JUN 19 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Heard H. Hines</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 19 1957

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6531

CERTIFICATE OF DEATH

06502

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosmar San. &amp; Hospital</u>				d. STREET ADDRESS <u>15506 Glenwood Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>B</u> Last <u>Kelling</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-31-1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret. Teacher</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>O.K. Walweber</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Klentz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Marcia Weidenlopf</u> Address <u>5506 Glenwood Rd. Bethesda - Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebro-Vascular Hemorrhage</u> DUE TO (c) <u>Generalized Arterio-Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 20</u> , 1953, to <u>June 19</u> , 1957, that I last saw the deceased alive on <u>June 19</u> , 1957, and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Merrill M. Cross</u>				ADDRESS (Street, city or town, state) <u>1245 Spring Ave. Md.</u>			
PHYSICIAN'S NAME (Type) <u>MERRILL M. CROSS M.D.</u>				DATE SIGNED <u>6/19/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>6/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chicago, Illinois</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-24-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			



BUREAU FILE

JUN 26 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06503

Reg. Dist. No. 218

6532

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Germantown, Md.</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Marylander Rest Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
				f. STREET ADDRESS <b>12,408 Flack Street</b>			
				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Joseph F.</b> Middle <b>Kelly</b> Last <b>Kelly</b>				4 DATE OF DEATH Month <b>June</b> Year <b>23</b> Day <b>19</b> Year <b>57</b>			
5 SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1885</b> <b>Feb. 12, 1884</b>	
				9 AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
				11 BIRTHPLACE (State or foreign country) <b>Elmira, N. Y.</b>			
13. FATHER'S NAME <b>Michael J. Kelly</b>				14. MOTHER'S MAIDEN NAME <b>Mary M. Hurley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
				17. INFORMANT <b>Joseph M. Kelly</b> Address <b>Maryland</b> <b>12408 Flack St., Silver Spring,</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Coarctation</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coarctation</b>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 7, 1956</b> to <b>23 June, 1957</b> , that I last saw the deceased alive on <b>June 23, 1957</b> , and that death occurred at <b>100 M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John G. Fawcett</b> M.D.				ADDRESS (Street, city or town, state) <b>P.O. Box 1, Md.</b>			
PHYSICIAN'S NAME (Type) <b>JOHN G. FAWCETT M.D.</b>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>TRANS. &amp; BURIAL</b>		<b>6/27/57</b>		<b>ST. MARY'S CEMETERY</b>		<b>HORSEHEAD, NEW YORK</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warren S. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>June 26-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Abraham G. Cook</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: Affix this certificate to the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 28 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6533

## CERTIFICATE OF DEATH

Reg. Dist. No.

06504

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Florida</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pensacola</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>828 North K Street</b>	
3. NAME OF DECEASED (Type or print) <b>Christine (None) Kennedy</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1929</b>
9. AGE (in years last birthday) <b>28</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unascertainable</b>	
14. MOTHER'S MAIDEN NAME <b>Unascertainable</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Admission to hospital</b> DUE TO <b>Heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> (c) <b>admission to hospital</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 27</b> , 19 <b>57</b> , to <b>June 22</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>57</b> , and that death occurred at <b>7:35 AM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>6/22/57</b>	
ACTUAL SIGNATURE <b>GURSTON GOLDIN, M. D.</b>		PHYSICIAN'S NAME (Type) <b>GURSTON GOLDIN, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6.24-57</b>	22b. DATE THEREOF <b>6.24-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pensacola</b>	22d. LOCATION (City, town, or county) (State) <b>FLA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fraziers Funeral Home</b>		24. REC'D BY REGISTRAR DATE <b>6/22/57</b>	
25. REGISTRAR'S SIGNATURE <b>Russell Thompson</b>		26. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form is to be filled out by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 27 1957

BRUNNEN & S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6446

## CERTIFICATE OF DEATH

06505

Reg. Dist. No. 223

1. PLACE OF DEATH o COUNTY <u>MONTGOMERY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>DC.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Park</u>				c. LENGTH OF STAY IN 1b <u>41 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hosp.</u>				d STREET ADDRESS <u>5012 Ar Mansaw Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Kessler</u>				4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1957</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-92</u>	9. AGE (In years last birthday) <u>65 yrs.</u>	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l. Employee Bus. of Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>		11. BIRTH PLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Kessler</u>				14. MOTHER'S MAIDEN NAME <u>Emilie Fender</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>		17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>						<u>6 mos</u>	
DUE TO (b) <u>Hypertensive heart disease</u>						<u>5 yrs</u>	
DUE TO (c) <u>Essential hypertension</u>						<u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent cerebral thromboses</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-4</u> 19 <u>57</u> to <u>6-15</u> 19 <u>57</u> that I last saw the deceased alive on <u>6-15</u> 19 <u>57</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel M. Bageant</u> M.D.				ADDRESS (Street, city or town, state) <u>Washington DC.</u> DATE SIGNED <u>6/15/57</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL M. BAGEANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-18-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Neal</u> ADDRESS <u>4812 90. Ave N.W.</u>				24a. REC'D BY REGISTRAR <u>JUN 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>William A. Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUN 20 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6534

## CERTIFICATE OF DEATH

Reg. Dist. No.

06506  
216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>				d. STREET ADDRESS <u>7100 MEADOW LANE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>L</u> Last <u>KETCHAM</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 23-1900</u>		9. AGE (In years last birthday) <u>56</u> yrs	IF UNDER 1 YEAR Months <u>11</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD LUCAS</u>				14. MOTHER'S MAIDEN NAME <u>EDITH GROVE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>A.C. KETCHAM</u>		Address <u>7100 MEADOW LANE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> <u>+20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>60x Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 1.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1957</u> to <u>June 1, 1957</u> , that I last saw the deceased alive on <u>May 31, 1957</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D.				ADDRESS (Street, city or town, state) <u>3927 Longmeadow St. 20012</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u>				DATE SIGNED <u>6/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>6/4/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>			



RECEIVED

JUN 7 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6535

CERTIFICATE OF DEATH

Reg. Dist. No.

065117

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove foundation</u>		e. STREET ADDRESS <u>914 Philip Powers Dr</u>	
3. NAME OF DECEASED (Type or print) <u>Bernard</u> First <u>Cashby</u> Middle <u>Kilby</u> Last		4. DATE OF DEATH <u>June</u> Month <u>12</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16, 1894</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Culpepper Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Kilby</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Doggett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Josephine Dixon Laurel Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis, Arterio Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteo arthritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>June 12, 1957</u> that I last saw the deceased alive on <u>6/9/57</u> , 12, and that death occurred at <u>2:15</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Laurel Md</u> DATE SIGNED <u>6/12/57</u>			
ACTUAL SIGNATURE <u>J.M. Bird</u> M.D.		DATE SIGNED <u>6/12/57</u>	
PHYSICIAN'S NAME (Type) <u>J.M. BIRD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE/THEREOF <u>6/15/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Federal Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Colman Manor, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Donaldson</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>JUN 10</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Esther L. Loring</u>

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JUN 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6447

## CERTIFICATE OF DEATH

Reg. Dist. No.

06508

223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>12 GRANT AVE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 GRANT AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE C. KING</u>		4. DATE OF DEATH <u>JUNE 23, 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 3, 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. SEELY HSG-VT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES R. KING</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE E. WALKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>MRS. OLIVE T. DUNN</u>		Address <u>12 GRANT AVE T.P. MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>16 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11, 1955</u> , to <u>June 11, 1957</u> ; that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James R. Coleman MD</u>		ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash. DC</u>	
DATE SIGNED <u>6/23/57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 26, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. JENNIE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FOREST GLEN, MONTGOMERY, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Coleman</u>		ADDRESS <u>25 Yearwood St NW DC</u>	
24a. REC'D BY REGISTRAR <u>J. Richmond</u>		24b. REG. STRA'S SIGNATURE <u>J. Richmond</u>	
DATE <u>6/25/57</u>			

RECEIVED

JUN 26 1957

BUREAU Y. S.

18 Grant the  
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HICHTCHADY  
1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

6448

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06509  
773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lakoma Park</b> c. LENGTH OF STAY IN 1b <b>10 Min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. San. and Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>P. G.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Langley Park</b> d. STREET ADDRESS <b>1355 Langley Way Apt. 101</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Ann</b> Last <b>Koval</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/20/28</b>
9. AGE (in years last birthday) <b>29</b> yrs.		IF UNDER 1 YEAR Months <b>29</b> Days <b>17</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>SOUTH DAKOTA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>BORNARD, BERNARD CLANCY</b>	
14. MOTHER'S MAIDEN NAME <b>MARIE Quilty</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Hospital Records</b> Address <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Arsenic Poisoning</b> IMMEDIATE CAUSE (a) <b>971.6</b> DUE TO <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Taken a quantity of Acme Weed Killer containing 42.5% arsenic</b>		20c. TIME OF INJURY Month, Day, Year <b>6/17/57</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) <b>Langley Pk.</b> (County) <b>P.G.</b> (State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/17/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/21/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. T. ALTAVULL</b> ADDRESS <b>3619-14th St N.W.</b>		24a. REC'D BY REGISTRAR <b>JUN 19 1957</b> 24b. REGISTRAR'S SIGNATURE <b>—</b>	

WASHDC

RECEIVED

JUN 14 1957

RECEIVED

6449

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, MD.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>16 hrs</u>				d. STREET ADDRESS <u>923 Gabel Court</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Susan Lynn Kuehling</u>				4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/14/56</u>	9. AGE (In years last birthday) yrs <u>16</u>	10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min. <u>16 25</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robt. Edward Kuehling</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - meningocock -</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/14/57</u> , 19 <u>57</u> , to <u>6/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/14/57</u> , 19 <u>57</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David St. Martin</u>				ADDRESS (Street, city or town, state) <u>2322 Blue Ridge Ave.</u>			
PHYSICIAN'S NAME (Type) <u>David St. Martin</u>				DATE SIGNED <u>6/17/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>6/17/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. John Roth</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
JUN 18 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

6536

CERTIFICATE OF DEATH

06511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillandale Md</b>		c. LENGTH OF STAY IN 1b <b>14 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillandale Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1732 Overlook Drive</b>			d. STREET ADDRESS <b>1732 Overlook Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Winfield</b> Last <b>Lanham</b>			4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 57</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 17, 1859</b>	9. AGE (In years last birthday) <b>97 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Collington Md</b>	
13. FATHER'S NAME <b>Stephen Lanham</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ellen Henry</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Alme L Fisher</b> Address <b>1732 Overlook Drive Hillandale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> 4210.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Senility.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 1/2</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diverticulosis of Colon.</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 1, 1951</b> to <b>June 5, 1957</b> that I last saw the deceased alive on <b>April 15, 1957</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>John R. Egan</b>		ADDRESS (Street, city or town, state) <b>1801 Eye St N.W. - Washington, D.C.</b>			
PHYSICIAN'S NAME (Type) <b>John R. Egan M.D.</b>		DATE SIGNED <b>1801 Eye St N.W. - Washington, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 8, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>		22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md.</b>		
24a. REC'D BY REGISTRAR <b>JUN 10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BUREAU V. 1

JUN 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06512

6537

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>				d. STREET ADDRESS <u>1508 North Kentucky Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Louise</u> Last <u>Larsh</u>				4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19-57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1917</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Key Punch Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Manning</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Progressive debilitation</u> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Disease</u> DUE TO (c) <u>Carcinoma of Endometrium</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>June 5, 1957</u> , to <u>June 21, 1957</u> , that I last saw the deceased alive on <u>June 21, 1957</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Clarence S. Weldon</u> M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland				ADDRESS (Street, city or town, state) DATE SIGNED <u>6/21/57</u>			
PHYSICIAN'S NAME (Type) <u>Clarence S. Weldon, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>June 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Thompson</u> ADDRESS <u>2847 Wilson Blvd., Arlington, Va.</u>				24a. REC'D BY REGISTRAR <u>6-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

JUN 3 1957

RECEIVED

6538

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

06513

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>25 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>				d. STREET ADDRESS <b>4634 Taney Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Aubrey</b> Middle <b>Travis</b> Last <b>LEAVELL</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 2, 1893</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Bowman B. LEAVELL</b>				14. MOTHER'S MAIDEN NAME <b>Annie B. CLATTERBUCK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or date of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Floyd W. LEAVELL</b> Address <b>Route 4, Culpeper, Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure &amp; pulmonary edema</b> DUE TO <b>1 day</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Resection of thoracic esophagus</b> DUE TO <b>8 days</b> (c) <b>Carcinoma of the esophagus</b> <b>5-6 months</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 6, 1957</b> to <b>June 1, 1957</b> , that I last saw the deceased alive on <b>June 1, 1957</b> , and that death occurred at <b>3:07 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Robert P. Dobbie</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md. 6-1-57</b>			
PHYSICIAN'S NAME (Type) <b>Robert P. DOBBIE, M.D.</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-3-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Culpeper, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Geest Funeral Parlor, Culpeper, Virginia</b>				24a. REC'D BY REGISTRAR DATE <b>6-1-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Farrelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

BUREAU V. S.

JUN 4 1957

RECEIVED

6539

## CERTIFICATE OF DEATH

Reg. Dist. No.

06514

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>CHEVY CHASE MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SURBURBAN</u>				d. STREET ADDRESS <u>4815 CHEVY CHASE DR.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN EVA</u> <u>LELAND</u>				4. DATE OF DEATH Month Day Year <u>JUNE 27 19 57</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 13 - 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>7 14</u>		IF UNDER 24 HRS Months Days Hours Min. <u>7 14</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RICHARD T. BUTLER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH HALL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-38-7004D</u>		17. INFORMANT <u>Charles B. Redmond</u>	
				Address <u>0032 Woodhill Rd. Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO <u>Toxemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>carcinomatosis advanced</u> DUE TO (c) <u>absence of one kidney surgically removed</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>absence of one kidney surgically removed</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>MAR. 1953</u> to <u>JUNE 27, 1957</u> , that I last saw the deceased alive on <u>JUNE 27</u> 19 <u>57</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7930 Georgia Ave. Silver Spring, Md.</u> DATE SIGNED <u>Benjamin Thompson</u> ACTUAL SIGNATURE <u>John O. Robben</u> M.D. PHYSICIAN'S NAME (Type) <u>John O. Robben</u> <u>7930 Georgia Ave. Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6-30-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Benjamin Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUL 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6540

CERTIFICATE OF DEATH

06515  
14

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ASHTON</u>				c. LENGTH OF STAY IN 1b <u>4 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>ASHTON, COLESVILLE RD</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE LYMAN LEMERLE</u>				4. DATE OF DEATH Month Day Year <u>6-13-1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1864</u>	9. AGE (in years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PHYSICIAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MEDICINE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>AUGUSTUS EUGENE LEMERLE</u>				14. MOTHER'S MAIDEN NAME <u>AIETTA MARR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>4910</u>			
17. INFORMANT <u>EUGENIE L. RIGGS, ASHTON, MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia Left.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumo-Pneumonia</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4910</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Ashton, MD</u>				20g. (County) <u>Montgomery</u>		20h. (State) <u>MD</u>	
21. I certify that I attended the deceased from <u>6/5/57</u> , 19 <u>57</u> , to <u>6/13/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/7/57</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Ashton, MD</u> DATE SIGNED <u>6/13/57</u>							
ACTUAL SIGNATURE <u>J. H. BIRD</u>				M.D. <u>Sanley Sp...</u>			
PHYSICIAN'S NAME (Type) <u>J. H. BIRD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>6/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Ashton, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley Jones</u>				ADDRESS <u>1755 P. Ave., N.W. DC</u>		24a. REC'D BY REGISTRAR <u>JUN 17 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Francis H. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU U.S.

MAY 17 1957

RECEIVED

6450

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN b. <u>6 days</u>				d. STREET ADDRESS <u>105 Hodges Lane</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Colin</u> Middle <u>Shaw</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-84</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DRY GOODS</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Eliza HORRELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis Pneumonia</u>							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II—OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>May 22, 1957</u> , to <u>June 7, 1957</u> , that I last saw the deceased alive on <u>June 7, 1957</u> , and that death occurred at <u>7:11 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7117 Wilkesboro Rd. Takoma Park, Md.</u> DATE SIGNED <u>June 7, 1957</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>							
PHYSICIAN'S NAME (Type) <u>A. P. Ruff</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>transit burial</u>		<u>June 5, 1957</u>		<u>Winton Park Cemetery</u>		<u>Wilkesboro, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carnegie Ave. S.E. Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u>[Signature]</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
6541										
06517										
Reg. Dist. No. 216										
CERTIFICATE OF DEATH										
It is 5, 2:G217 7-2-57 L										
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Hall San. 10231 Carroll Place</b>					d. STREET ADDRESS <b>3705 Dunlop Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <b>NAN</b> Middle <b>TRAVIS</b> Last <b>LINGLEY</b>					4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1957</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 27, 1883</b>		9. AGE (In years last birthday) <b>68 78</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Capital Transit</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>				
13. FATHER'S NAME <b>Frank M. Travis</b>					14. MOTHER'S MAIDEN NAME <b>Betty B. Collawn</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Son</b>					Address <b>Louis C. Paladini 3705 Dunlop St. Chevy Chase, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE MYO CARDITIS</b> (c) <b>CHRONIC MYO CARDITIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL SCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY 23, 1954</b> , to <b>JUNE 23, 1957</b> , that I last saw the deceased alive on <b>JUNE 23, 1957</b> , and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>5206 Norway Dr. 6/23/57</b> DATE SIGNED ACTUAL SIGNATURE <b>Henry M. Lowden</b> M.D. PHYSICIAN'S NAME (Type) <b>Henry M. Lowden</b> <b>Cheng Chen, M.D.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>6-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>			22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. Pumphrey</b>					ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6-24-57</b>		24b. REGISTRAR'S SIGNATURE <b>Beanie M. Thompson</b>	

BUREAU V. S.

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6542

## CERTIFICATE OF DEATH

06518

Reg. Dist. No. 276

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8212 CUSTER RD.</b>		d. STREET ADDRESS <b>8212 CUSTER RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>J</b> Last <b>MacKAVANAGH</b>		4. DATE OF DEATH Month <b>6</b> Day <b>4</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Lawyer &amp; Electrical Engineer Scotland</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>James MacKavanagh</b>		14. MOTHER'S MAIDEN NAME <b>Mary Coyle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>577-07-1543-A</b>	
17. INFORMANT <b>Rev. Kelgin J. MacKavanagh</b>		Address <b>Georgetown Prep. School D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>united</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb.</b> 1955 to <b>June 4</b> 1957 that I last saw the deceased alive on <b>June 4</b> 1957 and that death occurred at <b>4:55 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Willard Camalier, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>1801 Eye St. N.W. Wash. D.C.</b>	
DATE SIGNED <b>6/4/57</b>			
PHYSICIAN'S NAME (Type) <b>C. WILLARD CAMALIER, JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/6/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>Washington, D. C.</b>	
24a. REC'D BY REGISTRAR <b>June 8 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie Thompson</b>	



BUREAU V. S.

JUN 6 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

6543

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9810 Georgia Ave. Maple Lane Rest Home</b>		d. STREET ADDRESS <b>1851 Columbia Rd., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret Ryan Marshall</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1877</b>
9. AGE (In years last birthday) yrs <b>80</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph N. Ryan</b>		14. MOTHER'S MAIDEN NAME <b>Lucy F. McCormick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Arthur D. Yewell</b>		Address <b>Bethesda, Md. 6609 Oxton Road,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocarditis</b> 44-2-1 DUE TO (b) <b>cardiovascular recalc disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>31X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 da</b> <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar 6</b> , 19 <b>57</b> to <b>June 26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 25</b> , 19 <b>57</b> , and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1822 Biltmore St NW Wash D.C.</b> DATE SIGNED <b>June 26 57</b>			
ACTUAL SIGNATURE <b>E. E. Quayle</b>			
PHYSICIAN'S NAME (Type) <b>E. E. Quayle</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>6/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Old Chapel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Berryville, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>		ADDRESS <b>Wash. D.C.</b>	24a. REC'D BY REGISTRAR <b>JUN 28 1957</b>
		24b. REGISTRAR'S SIGNATURE <b>Francis P. Miller</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 28 1957

BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 06520 273									
1. PLACE OF DEATH a. COUNTY <u>MONTG</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRG</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillcrest Dr</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pat. R. 1 1/2 mi above St. Lucia</u>					d. STREET ADDRESS <u>2531 Colbrook Dr.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Preston Mays Jr</u>					4. DATE OF DEATH Month Day Year <u>June 26 1957</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-4-1949</u>		9. AGE (In years last birthday) <u>8</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>James Preston Mays Sr</u>					14. MOTHER'S MAIDEN NAME <u>Constance Phillips</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>James R Mays Sr - Same # 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial</u> <u>infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>drowning</u> DUE TO (c) <u>asphyxia</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Steped into deep water while fishing</u>			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour <u>3:25</u> <u>6/26</u> <u>1957</u> <u>P. M.</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac R</u>		20f. (City or town) <u>Potomac</u> (County) <u>Montg</u> (State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANK J. BROSCH</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>6-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) <u>Charlottesville Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamberlain</u> ADDRESS <u>517-11th St S.E.</u>					24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>James R Mays Sr</u>		
					DATE <u>JUN 28 1957</u>				

RECEIVED

JUN 28 1977

BUREAU V. S.

6545

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>7 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Valatie</b> d. STREET ADDRESS <b>Upper Main Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Virginia Mazal</b>		4. DATE OF DEATH Month Day Year <b>June 7th, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 14th, 1920</b>
9. AGE (In years last birthday) <b>36 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Arthur Mazal</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Sitzler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>074-14-9300</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>2nd stroke from atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pre-existing atherosclerosis</b> (c) <b>hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>6/4-6/7</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 31st, 1957</b> , to <b>June 7th, 1957</b> , that I last saw the deceased alive on <b>June 7th, 1957</b> , and that death occurred at <b>6:25 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 6/7/57</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Peter D. Olch, M. D.</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>6/7/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Niverville, New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-8-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 11 1957

BUREAU V. S.

6546

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OXON HILL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mrs. Green's Nursing Home</b>				d. STREET ADDRESS <b>5000-Longfellow Rd S</b>			
3. NAME OF DECEASED (Type or print) First <b>BENSON</b> Middle <b>P</b> Last <b>MCDANIEL</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 16, 1875</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Guard</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Thomas McDaniel</b>				14. MOTHER'S MAIDEN NAME <b>Not known.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Jane Cox</b> Address <b>101 Salisbury Dr. S.E. Wash., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage.</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Atherosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 Days.</b> <b>5 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>11211 congestive Heart Failure.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 12, 1957</b> to <b>June 2, 1957</b> , that I last saw the deceased alive on <b>June 2, 1957</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James A. Roberts</b> M.D.				ADDRESS (Street, city or town, state) <b>6907 GEORGIA AVE</b>		DATE SIGNED <b>6/2/57</b>	
PHYSICIAN'S NAME (Type) <b>JAMES A. ROBERTS M.D.</b>				SILVER SPRING, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Buried</b>		<b>6-5-57</b>		<b>Shiloh Meth. Cemetery</b>		<b>Pomonkey Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Demarous Bros</b>				ADDRESS <b>1661- Good Hope Rd SE WASH DC</b>		24a. REC'D BY REGISTRAR <b>JUN 4 1957</b>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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JUN 5 1957

BUREAU V. S.

TO HOSPITAL OR CITY, COUNTY, OR STATE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6547  
CERTIFICATE OF DEATH

06523

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN b <b>4 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>		d. STREET ADDRESS <b>305 Wasp Road</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mc Lain</b>		4. DATE OF DEATH Month Day Year <b>June 11 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/11/57</b>
9. AGE (In years last birthday) yrs <b>4</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Henry McLain</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Louise Youngman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>Mother Same #2</b>	
17. INFORMANT <b>Mother</b>		Address <b>Same #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Guns prematurity - wgt. 1-3 3/4</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/11</b> , 19 <b>57</b> , to <b>6/11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/11</b> , 19 <b>57</b> , and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>A. D. Bonifant</b> M.D. <b>Sandy Spring, Md.</b> <b>6/14/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation June 12, 1957</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George's Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>6/14/57</b>	
ADDRESS <b>Silver Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Stanley B. Lavelle</b>	

U. S. A.

21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6451

## CERTIFICATE OF DEATH

06524 223  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>				c. LENGTH OF STAY IN 1b <b>4 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>517 ALBANY AVENUE Oak Haven Conv. Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <del>XXXXXXXXXX</del> <b>PHILIP JACKSON</b> Middle Last <b>MEDLEY</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/21/62</b>	
9. AGE (In years last birthday) yrs. <b>94</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer - retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>		11. BIRTHPLACE (State or foreign country) <b>St. Mary's County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CHARLES MEDLEY</b>				14. MOTHER'S MAIDEN NAME <b>LOUISA ALLSTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. J. Ingram Medley, 7840 Aberdeen Rd. Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wind Pneumonia</b> DUE TO (b) <b>Infection plus pneumonia</b> DUE TO (c) <b>Plus 94+ yrs. age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <b>3-4 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 1956				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1953</b> , 19 <b>June 10, 1957</b> that I last saw the deceased alive on <b>May 31, 1956</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Chas H. Stolton M.D. 506 New York Ave NW Wash, DC</b> DATE SIGNED <b>6/10/57</b>							
ACTUAL SIGNATURE <b>Chas H. Stolton</b>				PHYSICIAN'S NAME (Type) <b>Chas H. Wolotton</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Thompson</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>6/14/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. Robinson</b>			

BUREAU V. S.

JUN 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6548

CERTIFICATE OF DEATH

06525

Reg. Dist. No. 2116

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>19-E. Lenox</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Curran</u> Last <u>Mendenhall</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1871</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Geological Survey</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm K. Mendenhall</u>		14. MOTHER'S MAIDEN NAME <u>Emma Pierce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Allice Mendenhall</u>		Address <u>9 E. Lenox Ch. Ch. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage from Gastrointestinal Tract</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Suspect Carcinoma COLON</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>June 2</u> , 19 <u>57</u> that I last saw the deceased alive on <u>June 2</u> , 19 <u>57</u> , and that death occurred at <u>3:40</u> P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Peyton R Evans Jr</u>		ADDRESS (Street, city or town, state) <u>5401 Western Ave NW</u>	
PHYSICIAN'S NAME (Type) <u>PEYTON R. EVANS JR</u>		DATE SIGNED <u>WASH DC 6-3-57</u>	
22a. BURIAL (CREMATION) REMOVAL (Specify)	22b. DATE THEREOF <u>6-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley's Sons, Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE 6-6-57</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1957

BUREAU V. 3

6549

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Chevy Chase) Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U.S. Naval Hospital</b>		d. STREET ADDRESS <b>5201 Chevy Chase Parkway, NW</b>	
3. NAME OF DECEASED (Type or print) First <b>Essie</b> Middle <b>Lucretia</b> Last <b>MICHAELIS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 4 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown (GISE)</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Son, Joseph L. MICHAELIS</b>		Address <b>Wheaton, Maryland 11906 Garner St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis</b> (c) <b>Intermittent Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>4 mos.</b> <b>11.5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450-1</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5</b> , 19 <b>57</b> , to <b>June 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>57</b> , and that death occurred at <b>9:58 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 6-11-57</b>			
ACTUAL SIGNATURE <b>Thomas S. Dunn, Jr.</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas S. DUNN, Jr. LT MG USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-14-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, Dist. of Columbia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Lee Sons, 4th &amp; Mass. Ave., N.E., Wash.,</b>		24. REC'D BY REGISTRAR DATE <b>6-11-57</b>	
24. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

JUN 12 1957

BUREAU V. E.

6452

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>Washington DC</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>			d. STREET ADDRESS <u>4421 48th St. N.W.</u>		
3. NAME OF DECEASED (Type or print) First <u>Axel</u> Middle <u>Conrad</u> Last <u>Millbrook</u>			4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/3/1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(Corson-Gruman) Construction Engineer</u>			11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		
13. FATHER'S NAME <u>Axel M. Millbrook</u>			14. MOTHER'S MAIDEN NAME <u>Anna Anderson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT Address <u>Hospital Records</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u>					<u>30 hrs</u>
600.0 DUE TO					<u>30 hrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u>					<u>1-2 yrs.</u>
DUE TO (c) <u>Chronic pyelonephritis</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>5/24</u> 19 <u>57</u> to <u>June 30 1957</u> that I last saw the deceased alive on <u>June 30</u> 19 <u>57</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Arthur J. Wilets</u>			ADDRESS (Street, city or town, state) <u>909 Pns. Bldg. Spring 4/30/57</u>		
PHYSICIAN'S NAME (Type) <u>Arthur J. Wilets</u>			DATE SIGNED <u>4/30/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/3/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901-14th St</u>			24a. REC'D BY REGISTRAR <u>DATE 7/1/57</u>		
			24b. REGISTRAR'S SIGNATURE <u>J. Wilets</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

6550

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13

06528  
Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>7 mo</u>		d. STREET ADDRESS <u>10208 Fleming Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10208 Fleming Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Ray Millie</u>		4. DATE OF DEATH <u>June 10 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-21-1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Capt Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Agnes McKie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Flourence Millie</u>	
17. INFORMANT <u>Flourence Millie</u>		Address <u>Same #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>6-10-57</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Bethesda, Md.</u>	24b. REGISTRAR'S SIGNATURE <u>Ben M. Thompson</u>

RECEIVED

JUN 19 1957

BUREAU V. S.

6551

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN IB <b>1 month 28 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				d. STREET ADDRESS <b>4700 Bradley Boulevard</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Isabelle</b> Last <b>MILSTEAD</b>				4. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1957</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 25, 1891</b>	9. AGE (In years last birthday) <b>66</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas Kenneth MORGAN</b>				14. MOTHER'S MAIDEN NAME <b>Blanche R. PADGETT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT Address <b>Husband, Wallace A. MILSTEAD (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Grand Mal Convulsions + inanition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Metastatic lesions from</b> DUE TO <b>Carcinoma, utero (endometrium)</b> (c) <b>1 1/2 yrs +</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>indefinite</b> <b>1 1/2 yrs +</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>April 10, 1957</b> , to <b>June 7, 1957</b> , that I last saw the deceased alive on <b>June 7, 1957</b> , and that death occurred at <b>4:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>6-7-57</b>							
ACTUAL SIGNATURE <b>George L. Johnson</b>				PHYSICIAN'S NAME (Type) <b>George L. Johnson, Jr., LTMCUSN/U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				24a. REC'D BY REGISTRAR DATE <b>6-7-57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Farrell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 10 1957

RECEIVED

6552

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Vermont</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN 1b <b>9 days</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mena</b> Middle <b>Delma</b> Last <b>Miner</b>		4. DATE OF DEATH Month <b>June</b> Day <b>11</b> , Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1930</b>
9. AGE (in years last birthday) <b>26 yrs</b>		FUND 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	11 BIRTHPLACE (State or foreign country) <b>Vermont</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Julius Paquette</b>	
14 MOTHER'S MAIDEN NAME <b>Stella Mercey</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>008-27-6316</b>		17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Air Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Open Heart Surgery.</b> DUE TO (c) <b>Congenital Heart disease Atrial Septal Defect</b>			INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>26 yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 2, 1957</b> , to <b>June 11, 1957</b> , that I last saw the deceased alive on <b>June 11, 1957</b> , and that death occurred at <b>12:29 P.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence E. Weldon</b>		DATE SIGNED <b>6/17/57</b>	
PHYSICIAN'S NAME (Type) <b>Clarence E. Weldon, M. D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	22b. DATE THEREOF <b>6/15/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>	22d. LOCATION (City, town, or county) (State) <b>St. Albans, Vermont</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>6-14-57</b>	24b. REGISTRAR'S SIGNATURE <b>Beane M. Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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JUN 17 1957

BUREAU V. S.

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06531

6453

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Washington, D. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>1746 Lamont St., N. W.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Phillip</u> Last <u>Morris</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>63</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Green L. Morris</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Hodges</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW #1</u>		17. INFORMANT Address <u>Hugh Morris, 3048 Oliver St., N. W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute auricular fibrillation</u> DUE TO " <u>200X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Ben Ben heart disease</u> DUE TO (c) <u>Arterio sclerosis - generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>3 hrs</u> <u>7</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition (severe)</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-25</u> , 19 <u>57</u> , to <u>6-26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-26</u> , 19 <u>57</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Wash. 10 P. C.</u> DATE SIGNED <u>E. H. Markwood</u>							
ACTUAL SIGNATURE <u>E. H. Markwood</u>		PHYSICIAN'S NAME (Type) <u>E. H. Markwood, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fort Myer, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence E. Humphrey</u>		ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. [Signature]</u>	

BUREAU V. S.

NOV 1 1957

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THIS MEDICAL EXAMINER: This certificate should be completed within 14 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. For a burial, cremation, or removal, see the instructions on the back of this form. File pages 1 and 2 with the registrar prior to funeral home or removal.

VS. A15ME(5)  
5M 9/55

6553

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06532

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>1 Hour 10 Min</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Avondale MOULDEN</b>				4. DATE OF DEATH Month Day Year <b>June 26 19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 20, 1894</b>	9. AGE (In years last birthday) <b>72</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Mont. County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William V. Beall</b>				14. MOTHER'S MAIDEN NAME <b>Mary Purdum</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Eleanor M. Cervenka, 3932 Washington Street Kensington, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1/541</b> DUE TO <b>Acute Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 hrs.</b> DUE TO (c) <b>2 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschert</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/29/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROCKVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ROCKVILLE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>6-30-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

BUREAU V. S.

JUL 8 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6554 CERTIFICATE OF DEATH

06533211  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodfield</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>10 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodfield</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gaithersburg B FD # I</b>		d. STREET ADDRESS <b>Gaithersburg RFD # I</b>	
3. NAME OF DECEASED (Type or print) <b>GEORGE</b> First <b>DAVID</b> Middle <b>MOYER</b> Last		4. DATE OF DEATH Month <b>JUNE</b> Day <b>II</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept, 10 1877</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ambrose Moyer</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Stormback</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217 32 1309</b>	
17. INFORMANT <b>Harriet M. Moyer,</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>It is the terminal disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 17, 1957</b> , to <b>June 17, 1957</b> , that I last saw the deceased alive on <b>June 17, 1957</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>6/17/57</b>			
ACTUAL SIGNATURE <b>James P. Kerr</b>		M.D. <b>Damascus, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 14 57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gray W. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>June 14/57</b>		24b. REGISTRAR'S SIGNATURE <b>Della O. Bunsdell</b>	

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JUN 18 1957

BUREAU V. 3

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06534

Reg. Dist. No. 216

6555

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Xd Bethesda</u> d. STREET ADDRESS <u>5148 Mass. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Bernadette M. Mulqueen</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>6/6/57</u> <u>19</u>					
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/14/52</u> <u>1900</u>		<b>9. AGE</b> (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Pa.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John Cauley</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Welch</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> (If yes, give war or dates of service)		<b>17. INFORMANT</b> Address <u>Hosp. Record</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Laceration + hemorrhage, Poss</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fall down stairs</u> (c), stating the underlying cause last, DUE TO								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>multiple lacerations cerebral cortex</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stair steps at home</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>1:30</u> o. m. <u>6/1/57</u> 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>home</u>		<b>20f. (City or town)</b> <u>Bethesda</u> <b>(County)</b> <u>Montg</u> <b>(State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>Frank J. Broschart</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>6/10/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cote of Heaven Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Montgomery County, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph Hawley Sons</u>				<b>ADDRESS</b> <u>1706 Pa. Ave., N.W.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE 6-11-57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

JUN 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6556

CERTIFICATE OF DEATH

06535  
Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3812 Woodbine St.</b>		d STREET ADDRESS <b>3812 Woodbine St.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Spencer</b> Last <b>Nesbitt</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1905</b>
9. AGE (In years last birthday) yrs <b>51</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>28</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Army Officer-Retired. U.S. Army</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kentucky</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William F. Nesbitt</b>		14. MOTHER'S MAIDEN NAME <b>Florence S. Spencer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Alice M. Nesbitt</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> DUE TO <b>CORONARY THROMBOSIS &amp; INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC HYPERTENSION</b> DUE TO (c) <b>8 YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 MINS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4-44X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-17</b> 19 <b>57</b> to <b>6-19</b> 19 <b>57</b> that I last saw the deceased alive on <b>6-19</b> 19 <b>57</b> , and that death occurred at <b>6:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1352 University Lane, Hyattsville, Md.</b> DATE SIGNED <b>6/26/57</b>			
ACTUAL SIGNATURE <b>Harold Sterling</b> M.D.		PHYSICIAN'S NAME (Type) <b>Harold Sterling</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/28/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>6-27-57</b>		24c. REGISTRAR'S SIGNATURE <b>Bessie H. Thompson</b>	

HOSPITAL ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 JUL 1

RECEIVED

6454

## CERTIFICATE OF DEATH

06536

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>6 days</u>				d. STREET ADDRESS <u>11016 New Hampshire Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON Schritarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FLORENCE NEUMANN</u>				4. DATE OF DEATH <u>June 11 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1889</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		11. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>			
13. FATHER'S NAME <u>MAY Rosebaum</u>				14. MOTHER'S MAIDEN NAME <u>Lend Gundersheim</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Milton Neumann</u> Address <u>11016 N.H. Ave Silver Spring</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, left middle cerebral</u> DUE TO <u>Max</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>30 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal insufficiency; Coronary atherosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, lactory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January</u> , 19 <u>57</u> , to <u>June 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>57</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>6780 New Hampshire Ave.</u> DATE SIGNED <u>6/11/57</u>							
ACTUAL SIGNATURE <u>Norman H. Rubenstein</u> M.D. <u>Takoma Park, Md.</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE/THEREOF <u>6/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedarvale</u>		22d. LOCATION (City, town or county) (State) <u>Wash., D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Wanzanovsky</u> ADDRESS <u>3501-14 St. N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>6/13/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 17 1957

RECEIVED

6455

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06537273

Item 2 G-219 1/9/57 GTE

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 16 <u>20 months</u>				d. STREET ADDRESS <u>4814 1st St NW 1372 Kenyon St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE MADISON NICHOLS</u>				4. DATE OF DEATH Month Day Year <u>June 1 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>CAUC.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 4 1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Thomas A. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Pratt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT <u>Hospital Record</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u>		DUE TO (b) <u>Posterior Coronary Occlusion (old)</u>		DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>? years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>24X</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/23/1955</u> to <u>June 1, 1957</u> , that I last saw the deceased alive on <u>June 1, 1957</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Takoma Park Md.</u>				DATE SIGNED <u>6/2/57</u>			
ACTUAL SIGNATURE <u>Robert A. Hare</u>				M.D. <u>Jakoma Park Md.</u>			
PRINT NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers</u>				ADDRESS <u>C. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>June 5 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>William H. Hare</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. 8

UN 5 1957

RECEIVED

## 6557 CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o STATE <b>Virginia</b> b COUNTY <b>Fairfax</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN 1b <b>20 days</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d STREET ADDRESS <b>622 Whispering Lane</b>	
3 NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>(none)</b> Last <b>Nirenberg</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>57</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 6, 1910</b>
9 AGE (In years last birthday) <b>47</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Program Analyst</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11 BIRTHPLACE (State or foreign country) <b>New York</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>Louis Nirenberg</b>	
14 MOTHER'S MAIDEN NAME <b>Sara Goldbart</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO <b>530-07-9706</b>		17 INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>probable cardiac arrhythmia</b>		<b>minutes</b>
DUE TO (b) <b>rheumatic heart disease &amp; mitral stenosis</b>		<b>5+ years</b>
DUE TO (c) <b>unknown causes</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour o m p. m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town)		(County) (State)
21. I certify that I attended the deceased from <b>June 5, 1957</b> to <b>June 25, 1957</b> , that I last saw the deceased alive on <b>June 25, 1957</b> , and that death occurred at <b>7:40 AM</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>Emery C. Herman, Jr.</b> M.D.		DATE SIGNED <b>6/25/57</b>
PHYSICIAN'S NAME (Type) <b>Emery C. Herman, Jr., M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c NAME OF CEMETERY OR CREMATORY
<b>CREMATION</b>	<b>JUNE 29 1957</b>	<b>CEDAR HILL CEMETERY</b>
22d LOCATION (City, town, or county)		(State)
<b>Suitland</b>		<b>MARYLAND</b>
23 FUNERAL DIRECTOR'S SIGNATURE		24a REC'D BY REG. STRAT. 24b REGISTRAR'S SIGNATURE
<b>Cherry Chase Funeral Home Wash D.C.</b>		<b>JUN 27 1957</b> <b>Bev Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

JUN 27 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6558

CERTIFICATE OF DEATH

Reg. Dist. No.

06539

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>17 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. General Hospital, Inc.</u>				e. STREET ADDRESS <u>Rt. #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Louise</u> Last <u>O'Connell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>19 57</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) yrs. <u>61</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeffrey O'Connell</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Costello</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart congestive heart failure</u> DUE TO 4-2-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic myocarditis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>5 hr</u> <u>10 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 24</u> , 19 <u>57</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A. D. Benifant</u> M.D. <u>Sandy Sping M.D.</u> <u>6/25/57</u> PHYSICIAN'S NAME (Type) <u>A. D. BENIFANT</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber, Laytonsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>6/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>Benjamin B. Lawler</u>	

BUNYAN V. S.

JUL 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6559

## CERTIFICATE OF DEATH

06540

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>				d. STREET ADDRESS <b>3107 Cathedral Ave. N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Peck</b>				4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/16/66</b>	
9. AGE (In years birth day) <b>91</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Rea Pattison</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Allen Peck</b> Address <b>3107 Cathedral Ave. N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED ATTERIOSCLEROSIS</b> DUE TO (c) <b>CHRONIC MYOCARDITIS</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SENILITY</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>MAY 28, 1954</b> , to <b>6-23, 1957</b> , that I last saw the deceased alive on <b>JUNE 23, 1957</b> , and that death occurred at <b>6:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5206 Narrows Dr.</b> DATE SIGNED <b>6/23/57</b> ACTUAL SIGNATURE <b>Henry M Lewdon</b> M.D. PHYSICIAN'S NAME (Type) <b>Henry M Lewdon</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b> ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>JUN 25 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Polley</b>	

BUREAU V. S.

JUN 25 1957

RECEIVED

6560

## CERTIFICATE OF DEATH

Reg. Dist. No.

06541 216

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE [Where deceased lived If institution Residence before admission] a STATE <b>New Jersey</b> b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN 1b <b>10 days</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e STREET ADDRESS <b>608 F Street</b>	
3 NAME OF DECEASED (Type or print) First <b>Paula</b> Middle <b>Jean Marie</b> Last <b>Pezzella</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 57</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>February 16, 1957</b>
9 AGE (In years lost birthday) yrs <b>3</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>29</b> Days <b>29</b> Hours <b>11</b> Min <b>57</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Infant)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Pezzella</b>		14. MOTHER'S MAIDEN NAME <b>Faith Romano</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>Cerebral Vessel.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>C</b>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Post op. Pulmonary Artery Construction</b>			<b>2 days</b>
DUE TO (c) <b>Concurrent Heart Disease Ventricular Septal Defect</b>			<b>4 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <b>June 4, 1957</b> , to <b>June 14, 1957</b> , that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>3:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clarence S. Weldon, M.D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
DATE SIGNED <b>6/14/57</b>			
PHYSICIAN'S NAME (Type) <b>Clarence S. Weldon, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/17/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Catherine's</b>	22d. LOCATION (City, town, or county) (State) <b>Monmouth County-New Jersey</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6-17-57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 19 1957

RECEIVED

6561

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>		d. STREET ADDRESS <b>Route #1</b>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Martin</b> Last <b>PHELPS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1887</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Andrew PHELPS</b>		14. MOTHER'S MAIDEN NAME <b>Annie MARTIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO <b>578-12-8048</b>	
17. INFORMANT <b>(Wife) MRS. Estella PHELPS (Same as #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>years.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 June</b> , 1957, to <b>29 June</b> , 1957, that I last saw the deceased alive on <b>28 June</b> , 1957, and that death occurred at <b>12:48A</b> , from the causes and on the date stated above. <b>21 (R.H.)</b> ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Russell Miller, Jr.</b> M.D. <b>U.S. Naval Hospital, Bethesda, Md. 6-29-57</b> PHYSICIAN'S NAME (Type) <b>RUSSELL MILLER, Jr., LT, MC, USN/U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1 July 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bealsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>R.A. Pumphrey, 7557 Wiso. Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-29-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary B. Parrelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. E.

17 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 1 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6456

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06543  
Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. San and Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>P.G.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Adelphia</b> d. STREET ADDRESS <b>3100 Bucklodge Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> First <b>Adolph</b> Middle <b>Plack</b> Last		4. DATE OF DEATH <b>6/13/57</b> Month <b>19</b> Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/18/37</b>
9. AGE (In years last birthday) <b>19</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nursery work</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Adolph H. Plack</b>		14. MOTHER'S MAIDEN NAME <b>Helen G. Boeck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Helen Plack</b> Address <b>Same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive peritoneal hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Rupture of the liver</b> (c) <b>Trauma to the abdomen</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dived about 30 ft and struck head on submerged rock</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:45</b> Hour <b>2:45</b> P. M. <b>6/13/57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>creek</b>	20f. (City or town) <b>Silver Spring</b> (County) <b>Montg</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>June 15, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>		22d. LOCATION (City, town, or county) <b>Prince George's County, Md</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b> ADDRESS <b>254 Carroll St NW DC</b>		24a. REC'D BY REGISTRAR <b>J. Wilson Ridd</b> DATE <b>6/15/57</b>	
		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JUN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14, 15, 16, 17, 18-5-57 et

Reg. Dist. No.

065442/3

6562

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Off Md-R 355 1½ mi. W. Clarksburg</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manor</b>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Andy</b> Last <b>Podgurski</b>		4. DATE OF DEATH Month <b>6</b> Day <b>22</b> Year <b>57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/4/20</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 YEAR Months <b>37</b> Days	IF UNDER 24 HRS. Hours <b>37</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pilot, Commercial</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Penna</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Andy Podgurski</b>	
14. MOTHER'S MAIDEN NAME <b>Frances Phillips</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>175-14-4480</b>		17. INFORMANT <b>Capital Airline Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries, Extreme</b> DUE TO (b) <b>Body &amp; Extremities badly Mutilated</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost, <b>Due to</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Airplane Accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>6/22/57</b> Hour <b>0:00</b> a. m. <b>xx</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>country</b>	20f. (City or town) <b>Clarksburg Montg. Md.</b> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>6/22/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Bonifac</b>	22d. LOCATION (City, town, or county) <b>Penna</b> (State) <b>Pa</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Miller Funeral Home. Manor. Pa.</b>		24a. REC'D BY REGISTRAR <b>JUN 25 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Lowell Kragtop</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUN 22 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6461

## CERTIFICATE OF DEATH

06545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville-</b> c. LENGTH OF STAY IN lb <b>Rockville</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Rest Home</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>151 South Adams St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>ANNA</b> Last <b>POTTS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 57</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 31, 1872</b>
9. AGE (In years last b. rthday) <b>84</b> yrs		IF UNDER 1 YEAR Months <b>10</b> Days <b>16</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jessie N. Potts</b>		14. MOTHER'S MAIDEN NAME <b>Anna Cowman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Martha Burdette- Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Genit. Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4. Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 June 57</b> <b>20 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 46</b> to <b>17 June, 19 57</b> , that I last saw the deceased alive on <b>17 June, 1957</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rockville, Maryland</b> DATE SIGNED <b>17 June 1957</b>			
ACTUAL SIGNATURE <b>W. S. Murphy</b> M.D.		PHYSICIAN'S NAME (Type) <b>Rockville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>21 57</b>		24b. REGISTRAR'S SIGNATURE <b>Pumphrey</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

JUN 21 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

6563

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				d. STREET ADDRESS <b>12019 Georgia Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>WOODROW</b> Last <b>PRATT</b>				4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>February 24, 1913</b>		9. AGE (In years last birthday) <b>44 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Landscaping</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Thomas Pratt</b>				14. MOTHER'S MAIDEN NAME <b>Mary Louise Turner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW II 578-10-0512</b>		17. INFORMANT <b>Charles A. Pratt</b>		Address <b>12019 Georgia Avenue Silver Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage of the pons</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertention</b> (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cause of death</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Reported to have been in fight which had nothing to do with/</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>1200 6 - 9 19 57</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Silver Spring Montgomery Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walter</b>				24a. RECEIVED BY REGISTRAR <b>11 1957</b>		24b. REGISTRAR'S SIGNATURE	



RECEIVED

JUN 11 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6564

## CERTIFICATE OF DEATH

06547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wood Acres</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wood Acres</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5600 Harwick Road</u>		d. STREET ADDRESS <u>5600 Harwick Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine Sharpe Putnam</u>		4. DATE OF DEATH Month Day Year <u>June 2, 1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/14/1900</u>
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Greensboro, N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jules Sharpe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Donnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Clarence I. Sanders</u>		Address <u>unknown</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Metastatic Pulmonary Carcinoma</u> DUE TO <u>110X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Breast Carcinoma</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo 3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cervical + Lumbar Spine Metastasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 3, 1957</u> to <u>June 2, 1957</u> , that I last saw the deceased alive on <u>June 2, 1957</u> , and that death occurred at <u>2:40 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. J. Brennan</u> M.D.		ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/4/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co, 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>JUN 5 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>H. H. Hines</u>			

BUREAU V. S.  
JUN 1950  
JUN 1950

6565

## CERTIFICATE OF DEATH

Reg. Dist. No.

06548

216

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 45 days		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3827 Kansas Avenue, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Della		First Queen		Middle Rattley		Last		4. DATE OF DEATH Month June		Day 22		Year 19 57	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1907		9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Tall Foster		14. MOTHER'S MAIDEN NAME Mattie Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Malignant Lymphosarcoma - Mycosis Fungoides 4 yrs (c) Bilateral Pleural Effusions		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from May 8, 19 57, to June 22, 19 57, that I last saw the deceased alive on June 22, 19 57, and that death occurred at 11:22 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 6/23/57	
22a. DATE OF BURIAL, CREMATION, OR REMOVAL (Specify) 6-26-57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Carnegie		22d. LOCATION (City, town, or county) Maryland		22e. (State)		23. FUNERAL DIRECTOR'S SIGNATURE W. Ernest Jarni 1432 G St N.W.		24a. REC'D BY REGISTRAR JUN 25 1957	
24b. REGISTRAR'S SIGNATURE Leslie Thompson		24c. (City, town, or county)		24d. (State)		24e. (City, town, or county)		24f. (State)		24g. (City, town, or county)		24h. (State)	

MEDICAL CERTIFICATION

1. HOSPITAL OR ATTENDING PHYSICIAN: The low equi that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

6566

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Sensabaugh</b> Last <b>REAL</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 11, 1934</b>	9. AGE (In years last birthday) yrs <b>23</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Leon SENSABAUGH</b>				14. MOTHER'S MAIDEN NAME <b>Mary GREER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Jack O. REAL (Husband)</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Staphylococcal pneumonia - bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>BRONCHIAL ASTHMA</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>16 years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FULL TERM PREGNANCY DELIVERED 5/28/57</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>May 27</b> , 19 <b>57</b> , to <b>June 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 3</b> , 19 <b>57</b> , and that death occurred at <b>1055 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>6-3-57</b>							
ACTUAL SIGNATURE <b>Harold I. Passes</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Harold I. Passes, LT, MC, USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-8-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Birmingham, Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-3-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 5 1937

RECEIVED

6567

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06550 13

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Virginia</b> <span style="float: right;">b. COUNTY <b>Fairfax</b></span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Swains Lock</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Potomac River</b>				d. STREET ADDRESS <b>6402 Powell St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Richard</b> Last <b>Rice</b>				4. DATE OF DEATH <b>6/17/57</b> Month Day Year				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/7/42</b>		
9. AGE (In years last birthday) <b>14</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>school</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James R. Rice</b>				14. MOTHER'S MAIDEN NAME <b>Margaret C. Davis</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mother Same as Item 2</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>229.9</b> DUE TO <b>Drowning</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Drowned while swimming in Potomac River</b>						
20c. TIME OF INJURY Hour <b>5:30</b> P. M. <b>6/17/57</b> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Potomac River</b>		20f. (City or town) <b>Swains Lock Montg. Md.</b> (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6/18/57</b> DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 21, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church, Va.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. E. Crickberger</i> ADDRESS <b>Vienna, Va.</b>				24a. RECEIVED BY REGISTRAR <b>JUN 24 1957</b> DATE 24b. REGISTRAR'S SIGNATURE <i>Lawrence H. Heston</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED  
JUN 24 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6568

## CERTIFICATE OF DEATH

Reg. Dist. No.

06551  
217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>13 1/2 Hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>14600 Colesville Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Victoria</u> Last <u>Richardson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/69</u>		9. AGE (In years last birthday) <u>88</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Jacob V. Van Horn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Lula Edwards</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Asthma</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> 19 <u>57</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/11</u> 19 <u>57</u> to <u>6/15</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6/15</u> 19 <u>57</u> , and that death occurred at <u>2:30 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. W. Bird, M. D.</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u>		DATE SIGNED <u>6/15/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Bird, M. D.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>6/17/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bertie B. Lawler</u>			

U. S.

1907

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6569

## CERTIFICATE OF DEATH

06552  
214

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Maryland</b> b COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b>		c. LENGTH OF STAY IN 1b <b>1 Week</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Le Deau Gardens rest Home</b>		d. STREET ADDRESS <b>2721 Nicholson St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>Richter</b> Last <b>Richter</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23,</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1882</b>
9. AGE (In years last birthday) yrs <b>75</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Germany</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unk. Schenck</b>		14. MOTHER'S MAIDEN NAME <b>Unk. Dorothea Damm</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Dorothea Damm</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompenstation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Pyelonephritis</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. g. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 27</b> , 19 <b>54</b> , to <b>June 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>57</b> , and that death occurred at <b>—</b> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Ronald S. Fleischer</b> M.D.		ADDRESS (Street, city or town, state) <b>5432 QUEENS CHAPEL Rd Hyattsville Md</b>	
PHYSICIAN'S NAME (Type) <b>RONALD S. FLEISCHER</b>		DATE SIGNED <b>6/24/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 26, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIA <b>George Washington</b>	22d. LOCATION (City, town, or county) (State) <b>Hyattsville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Josch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Francis P. [Signature]</b>	

RECEIVED

JUN 28 1957

BUREAU V. S.

6570

## CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenelg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Washington</b> Last <b>Ridgely</b>		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 57</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/23/89</b>	9. AGE (In years last birthday) <b>68</b> yns.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Ridgely</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Day</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT <b>Hospital Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute cardiac failure</b> DUE TO (b) <b>toxic myocarditis</b> DUE TO (c) <b>Bronchopneumonia</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>431X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 21, 1957</b> , to <b>June 22, 1957</b> , that I last saw the deceased alive on <b>June 22, 1957</b> , and that death occurred at <b>11:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clarksburg, Md.</b> DATE SIGNED <b>6/22/57</b>							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		M.D. <b>C. S. Whitaker, M. D.</b>					
PHYSICIAN'S NAME (Type) <b>C. S. Whitaker, M. D.</b>		Village <b>Clarksburg, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>				Ellicott City, Md.		24a. REC'D BY REGISTRAR <b>JUN 25 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Katherine Lanning</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1967

RECEIVED

6571

CERTIFICATE OF DEATH

06554

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 16. 1. x 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>5119 NEWPORT AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROMULVS</u> Middle <u>RODMAN</u> Last				4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-12-1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>FEARSON RODMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE (NOT KNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>RUSSELL RODMAN - SON</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Pulmonary Infarction and</u> <u>165X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>extensive Bronchopneumonia</u> DUE TO (c) <u>primary Carcinoma of lung.</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>465X</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 12, 1957</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>DeWitt E. DeLawter</u> M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>6/12/57</u>	
PHYSICIAN'S NAME (Type) <u>DeWitt E. DeLawter, M.D.</u>				8025 ABERDEEN RD Bethesda 14, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg R.d Washington D</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 6-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	



RECEIVED

1 17 1957

BUREAU V. S.

6572

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery COUNTY MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bethesda		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4913 Bayard Boulevard		STREET ADDRESS (If rural give location) 4913 Bayard Boulevard	
3. NAME OF DECEASED: (Type or Print) Harriet L. Runbeck		4. DATE (Month) (Day) (Year) OF DEATH June 19 1957	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 2/9/1883
9. AGE last birthday IF UNDER 1 YEAR Months Days 74 yrs. 4 10		10. BIRTHPLACE (State or foreign country): Virginia	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: own home	
11. CITIZEN OF WHAT COUNTRY? USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown Farish	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: Merl Sliter--address unknown		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
10.4 IMMEDIATE CAUSE (A) Pneumonia		36 hrs.	
ANTECEDENT CAUSE (B) ileostomy 2° intestinal obstruction (pos perforative)		5 wks.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 1957		19B. MAJOR FINDINGS OF OPERATION: intestinal obstruction due to gall stone.	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW DID INJURY OCCUR?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 5, 1957, to June 19, 1957, that I last saw the deceased alive on June 18, 1957, and that death occurred at 6:10 P.M. from the causes and on the date stated above.			
SIGNATURE: [Signature]		DATE SIGNED: 19 June 57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial		DATE THEREOF: 6/22/57	
NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory		LOCATION (City, town, or county) (State): Suitland, Maryland	
DATE REC'D BY LOCAL REGISTRAR: 6-24-57		REGISTRAR'S SIGNATURE: [Signature]	
24. FUNERAL DIRECTOR: Robert A. Pumphrey		ADDRESS: Bethesda, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU W. S.

JUN 27 1927

RECEIVED

6573

## CERTIFICATE OF DEATH

06558

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington 47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>1425 Congress Place, S.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>Willie</b> Middle <b>(nmn)</b> Last <b>RUSH</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 9, 1957</b>		9. AGE (In years last birthday) yrs. <b>11</b> 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Willie Lee RUSH</b>				14. MOTHER'S MAIDEN NAME <b>Juanita L. DEAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Father, Willie Lee RUSH (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PREMATURITY 26-28</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GESTATION.</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 9, 1957</b> , to <b>June 10, 1957</b> , that I last saw the deceased alive on <b>June 10, 1957</b> , and that death occurred at <b>2:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>							
ACTUAL SIGNATURE <b>Daniel Shuptar</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md. 6-11-57</b>			
PHYSICIAN'S NAME (Type) <b>Daniel SHUPTAR, LT, MC, USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-12-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>U.S. Naval Medical School</b>		22d. LOCATION (City, town, or county) (State) <b>Bethesda 14, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Naval Medical School, NNMC, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>6-12-57</b>			
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 14 1967

BUREAU V. S.

6457

CERTIFICATE OF DEATH

06557

Reg. Dist. No.

273

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>29 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp</u>				e. STREET ADDRESS <u>5303 Glawood Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Effie</u> Last <u>Rusk</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/72</u>	9. AGE (In years last birthday) <u>55</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ill</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Hammerbacher</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Hosp Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>							<u>2 wks</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis + old thrombosis</u>							<u>3 months</u>
(c) <u>Hypertension</u>							<u>7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>446X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 24</u> , 19 <u>57</u> , to <u>June 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/21</u> , 19 <u>57</u> , and that death occurred at <u>7:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H Wolohin</u>				DATE SIGNED <u>6/27/57</u>			
PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>				M.D. <u>Wash. DC</u>			
22a. BURIAL, CREMATION, REMOVAL, or disposal <u>6/25/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat. Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				ADDRESS <u>Wash, D.C.</u>		24b. REC'D BY REGISTRAR <u>JUN 24 1957</u>	
				24c. REGISTRAR'S SIGNATURE <u>J. Wilson, Sec. Reg.</u>			

BUREAU V. S.

1957

RECEIVED

6574

06558

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN TB <b>17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>2209 40th Street, N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Joseph</b> Last <b>RYAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 3, 1904</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>William Bernard RYAN</b>				14. MOTHER'S MAIDEN NAME <b>Leelinau LUTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>(Sister) Mrs. Leelinau MC DONALD (Same as #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pericarditis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b> <b>indefinite</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3, 1957</b> , to <b>June 20, 1957</b> , that I last saw the deceased alive on <b>June 20, 1957</b> , and that death occurred at <b>9:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Henry B. Karpinski</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md. 6-20-57</b>			
PHYSICIAN'S NAME (Type) <b>Henry B. KARPINSKI, LT MC USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b>				ADDRESS <b>2901 14th St., N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>6-20-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Sanelly</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. 3

JUN 24 1957

RECEIVED

6575

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>Rockville</u>				c. LENGTH OF STAY IN 1b _____			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>				d. STREET ADDRESS <u>2319 King Place N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>NELLIE J SAUNDERS</u> First Middle Last				4. DATE OF DEATH <u>JUNE 25 19 57</u> Month Day Year			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 9 18 73</u>	9. AGE (In years last birthday) <u>83</u> yrs	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS Hours _____	Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>DEXTER DRAKE</u>				14. MOTHER'S MAIDEN NAME <u>JULIETT SANDERSONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>DR. C. K. SAUNDERS 2319 KING PLACE</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic HEART DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u> <u>2 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>JUNE 19 55</u> to <u>JUNE 25 19 57</u> that I last saw the deceased alive on <u>JUNE 22 19 57</u> and that death occurred at <u>4 2</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>William T. Saccardi</u> M.D. <u>23</u> <u>6/25/57</u> PHYSICIAN'S NAME (Type) <u>WILLIAM T SACCARDI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>6/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY _____		22d. LOCATION (City, town, or county) (State) <u>Cleveland, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Company, 2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Francis P. Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

6576

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Filed 7-2-57 et

CERTIFICATE OF DEATH

06560

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		d. STREET ADDRESS <u>1115-12th St., N. W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Sherlock</u> Last <u>Sherlock</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1869</u>
9. AGE (In years last birthday) <u>87</u> yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Sherlock</u>		14. MOTHER'S MAIDEN NAME <u>Belle Seymour</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Miss Mildred Pope</u>		Address <u>Washington, D.C.</u> <u>926 Mass. Avenue N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10+ years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 1954</u> , to <u>June 24, 1957</u> that I last saw the deceased alive on <u>June 23, 1957</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albion W. Eger</u> M.D.		ADDRESS (Street, city or town, state) <u>Washington, D.C.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Albion W. Eger</u>		1801 Eye Street, N.W.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>June 26-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>J. W. Lee's Sons Co.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons Co. - 300-4th St. N.E.</u>		24a. REC'D BY REGISTRAR <u>6-27-57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

JUL 1 1957

BUREAU V. S.

6577

## CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>9800 Great Falls Road</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural- Rockville</b>		d. STREET ADDRESS <b>9800 Great Falls Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mattie</b> Middle <b>Elizabeth</b> Last <b>SHORB</b>		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>13</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hamilton R. Geisbert</b>		14. MOTHER'S MAIDEN NAME <b>Martha R. Ramsburg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Glenn W. Shorb-Same Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>adenocarcinoma of rectum</b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1, 1956</b> to <b>6/21/1957</b> , that I last saw the deceased alive on <b>6/21/1957</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.		ADDRESS (Street, city or town, state) <b>Rockville Md</b> DATE SIGNED <b>6/22/57</b>	
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones, M.D.</b>		<b>Rockville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/24/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-7557 Wisconsin Avenue</b>		24a. REC'D BY REGISTRAR <b>JUN 24 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Llewellyn H. Taylor</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 21 1957

RECEIVED

6462

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>718 E. Montgomery Ave.</b>		d. STREET ADDRESS <b>718 E. Montgomery Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>XXX</b> First <b>Ellie</b> Middle <b>Simmons</b> Last <b>Simmons</b>		4. DATE OF DEATH <b>June 30, 1957</b> Month <b>June</b> Day <b>30</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 19, 1873</b>
9. AGE (In years last birthday) <b>83</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>11</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Bennett Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Barnes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dennis C. Simmons-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b> (c) <b>Arterio-sclerotic C-v disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>1 hr</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic gall-bladder disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 14, 1956</b> , to <b>June 30, 1957</b> , that I last saw the deceased alive on <b>June 30, 1957</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.		ADDRESS (Street, city or town, state) <b>Rockville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b>		DATE SIGNED <b>6/30/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Walker Farm Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tyrrell County, N. Carolina</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>7/2/57</b>		24b. REGISTRAR'S SIGNATURE <b>Laurel King</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. 8

11. 5 1957

RECEIVED

6578

## CERTIFICATE OF DEATH

Reg. Dist. No.

06563  
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Grant</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gorman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>Route 1, Box 98</u>	
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Dailey</u> Last <u>Simmons</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 9, 1902</u>
9. AGE (In years last birthday) yrs. <u>54</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Simmons</u>		14. MOTHER'S MAIDEN NAME <u>Cora Pifer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-7991</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Causes of death, metastatic</u> <u>DUPLICATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Exhaustion and compression</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Septicemia</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December 27, 19 56</u> , to <u>June 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>57</u> , and that death occurred at <u>6:15 p.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>6/16/57</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
ACTUAL SIGNATURE <u>Peter D. Olch, M.D.</u> M.D. <u>The Clinical Center</u>		6/16/57	
PHYSICIAN'S NAME (Type) <u>Peter D. Olch, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u>
23. FUNERAL DIRECTOR'S NAME <u>W. F. Bickel</u>		24a. REC'D BY REGISTRAR <u>501 L St., N.W. Wash., D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>Beatrice Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S.

JUN 20 1957

RECEIVED

6579

## CERTIFICATE OF DEATH

06564

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Beall Mountain, Rockville, Md.</b>		d. STREET ADDRESS <b>Beall Mountain</b>	
3. NAME OF DECEASED (Type or print) <b>Lyndon F Small</b>		4. DATE OF DEATH <b>6 15 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHD-Scientist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Research</b>	9. AGE (In years last birthday) <b>59</b> yrs. <b>9</b> Months <b>9</b> Days <b>29</b> Hours <b></b> Min.
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick E. Small</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Cary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. M. C. Small</b>		Address <b>item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Carcinoma of esophagus with metastases to pleural cavity</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>Dec 26, 1956 to June 16, 1957</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1957</b> to <b>death</b> , 19 <b></b> , that I last saw the deceased alive on <b>6/13</b> , 19 <b>57</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lyndon F. Lee Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>U.S. Veterans Admin - Washington 26, D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Lyndon F. Lee Jr. M.D.</b>		DATE SIGNED <b>26</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>6/17/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>6/19/57</b>		24b. REGISTRAR'S SIGNATURE <b>Laurel Kragtorp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

RECEIVED

JUN 20 1957

BUREAU A. B.

6580

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06565

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Takoma Park</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b <u>16 yrs</u>		d. STREET ADDRESS <u>517 Albany Pl. Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helene</u> First <u>L</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH <u>6/25/57</u> 19 <u>57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1888</u> 69 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Syracuse, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>441X</u>	
17. INFORMANT <u>John C. Smith</u> Address <u>2400</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Hypertension + gen. arteriosclerosis</u> DUE TO (c) <u>7 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>441X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1, 1957</u> to <u>June 25, 1957</u> that I last saw the deceased alive on <u>6/25, 1957</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D.B. Washington</u> M.D.		ADDRESS (Street, city or town, state) <u>6234 3rd Ave N.W. Wash D.C. 6/25/57</u>	
PHYSICIAN'S NAME (Type) <u>D.B. Washington MD</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Assumption Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Syracuse N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.K. Huntman &amp; Son</u> ADDRESS <u>5732 La Gre N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>6/28/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilson Decht.</u>			

RECEIVED

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6581

06566

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XIKENSINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAMELA LEE SORRELL</u>				4. DATE OF DEATH Month Day Year <u>JUNE 8 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-2-1957</u>	
9. AGE (In years last birthday) yrs. <u>6</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>FRED SORRELL</u>			
14. MOTHER'S MAIDEN NAME <u>ETHEL WILSON</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>FRED SORRELL</u> Address <u>10905 DRUMM AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (6 1/2 months gestation)</u> DUE TO (c) <u>6 days</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUNE 2</u> , 19 <u>57</u> , to <u>JUNE 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>JUNE 8</u> , 19 <u>57</u> , and that death occurred at <u>5:25 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sydney Ross M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>5414 Conn. Ave. NW Wash. DC</u>			
PHYSICIAN'S NAME (Type) <u>Sydney Ross M.D.</u>				DATE SIGNED <u>6-11-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Rumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>6-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Beaumont Thompson</u>	



RECEIVED

JUN 12 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6582

CERTIFICATE OF DEATH

06567

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4319 Center Street</b>		d. STREET ADDRESS <b>4319 Center Street</b>	
3. NAME OF DECEASED (Type or print) First <b>M.</b> Middle <b>ROSALIE</b> Last <b>SPROW</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/6/1903</b>
9. AGE (In years last birthday) yrs <b>53</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dietician</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Leopold, Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Solbrig</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Goffinet</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>308-24-7199</b>	
17. INFORMANT <b>Evelyn Richardson, (Same as # 2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of Liver</b> DUE TO (c) <b>Hepatitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 4 1:1</b> <b>2 yrs</b> <b>2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1955</b> to <b>6/27/57</b> , that I last saw the deceased alive on <b>6/26/57</b> , 19 <b>57</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. B. Sims</b>		DATE SIGNED <b>6/27/57</b>	
PHYSICIAN'S NAME (Type) <b>W. B. SIMS, M.D.</b>		ADDRESS (Street, city or town, state) <b>Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley Sons</b>		24a. REC'D BY REGISTRAR <b>DATE 6-27-57</b>	
ADDRESS <b>1756 Pa. Ave., N.W. DC</b>		24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 1

NOV 19 1977

RECEIVED

6458

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. &amp; Hospital</u>				d. STREET ADDRESS <u>12416 Denley Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>Leo</u> Middle <u>Stapleton</u> Last				4. DATE OF DEATH <u>June</u> Month <u>29</u> Day <u>1957</u> Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-5-89</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR: Months <u>6</u> Days <u>17</u> Hours <u>15</u> Min.		IF UNDER 24 HRS: Months <u>0</u> Days <u>1</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Mr. James Stapleton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> <u>WW #1</u>				16. SOCIAL SECURITY NO. <u>214-03-4072-A</u>		17. INFORMANT <u>Chart</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u>							
DUE TO <u>MASSIVE BLEEDING FROM</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>GASTRIC ULCERS</u>						<u>2 wks.</u>	
DUE TO <u>SHOCK</u>							
(c) <u>POST-SUBTOTAL GASTRECTOMY</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>27 JUNE, 1957</u> to <u>29 JUNE, 1957</u> that I last saw the deceased alive on <u>29 JUNE, 1957</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Frederick B Brandt</u> M.D.				ADDRESS (Street, city or town, state) <u>1726 Eye NW, D.C.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>FREDERICK B. BRANDT</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>7/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Doherty</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6463

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <b>District of Columbia</b> <b>COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>10 Months</b>		d. STREET ADDRESS <b>3636 - 16th St., N. W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Congressional Manor Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>N.</b> Last <b>STEINER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1890</b>
9. AGE (In years last birthday) <b>67</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>4</b> Days <b>19</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't Retired</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Benjamin Weems</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rutherford</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Robert F. Steiner</b>		Address <b>5810 Wilmett Road Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> <b>420.1</b> DUE TO <b>Arteriosclerosis &amp; Thrombosis Coronary</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b> DUE TO <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Myocardial infarction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1, 1957</b> to <b>June 13, 1957</b> that I last saw the deceased alive on <b>June 11, 1957</b> , and that death occurred at <b>5:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>809 Viers Mill Rd. Rockville, Maryland</b> DATE SIGNED <b>6/14/57</b>			
ACTUAL SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.		809 Viers Mill Rd. 6/14/57	
PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr.</b>		Rockville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-18-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert C. Humphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>6/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Lance K. Kratochvil E.C.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 18 1957

BUREAU V. E.

6583

## CERTIFICATE OF DEATH

Reg. Dist. No.

274

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16315 Haywood Dr.</u>				d. STREET ADDRESS <u>10305 Haywood Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Stern</u> Middle Last				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>20</u> Days <u>20</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Mandel Stern</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Fine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hetty Stern</u> Address <u>10305 Haywood Dr.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE CORONARY OCCLUSION</u> DUE TO (c) <u>ARTERIOSCLEROTIC C.V.D.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr</u> <u>2 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6:20</u> , 19 <u>57</u> , to <u>6:20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6:20</u> , 19 <u>57</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard H. Ostrow</u> M.D.				ADDRESS (Street, city or town, state) <u>7961 Eastern Ave., Sil. Spg., Md.</u>			
DATE SIGNED <u>6-20-57</u>							
PHYSICIAN'S NAME (Type) <u>Bernard H. Ostrow</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Va.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danyansky &amp; Sons</u>				24a. REC'D BY REGISTRAR DATE <u>6/28/57</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUL 2 1967

RECEIVED

6584

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b <b>2 weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hosp.</b>		d. STREET ADDRESS <b>1500 East West Highway</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hanna</b> Middle <b>S</b> Last <b>Stewart</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1894</b>
9. AGE (In years last birthday) yrs <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Calvin Saltzer</b>		14. MOTHER'S MAIDEN NAME <b>Emma Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Harrison M. Stewart</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 1/2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Log in Aberrant tuberculosis with generalized hemorrhage</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Silver Spring, Maryland</b>		(County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>29 June</b> , 19 <b>57</b> , and that death occurred at <b>10:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. Marshall Cuvillier</b> M.D.		ADDRESS (Street, city or town, state) <b>1407 Woodside Parkway, Silver Spring, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>L. Marshall Cuvillier</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-2-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. O'Brien</b>		24a. REC'D BY REGISTRAR <b>3821 14th St. N.W. D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Benjamin Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6585

## CERTIFICATE OF DEATH

06572  
 Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SUBURBAN</u>				d. STREET ADDRESS <u>5311 LOCUST AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSE CYRUS Stoddard</u>				4. DATE OF DEATH Month Day Year <u>JUNE 27 1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16 1886</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Josiah Stoddard</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>John C. Stoddard</u>				Address <u>Bethesda - 9514 - MISTAD. DR.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral confluent bronchopneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>20 June, 1957</u> to <u>27 June, 1957</u> , that I last saw the deceased alive on <u>27 June, 1957</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Verace W. Vernon M.D.</u>				ADDRESS (Street, city or town, state)			
DATE SIGNED				DATE SIGNED			
PHYSICIAN'S NAME (Type)				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pullen</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>6-30-57</u>	
24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>				24c. REGISTRAR'S SIGNATURE			

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**HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

6536

## CERTIFICATE OF DEATH

Reg. Dist. No.

06573

2/12

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>2 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DICKERSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>ROUTE 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>FREDERICK</b> Middle <b>STONE</b> Last		4. DATE OF DEATH Month <b>6</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/5/76</b>	9. AGE (In years last birthday) <b>80</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>GEORGE C. STONE</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN N. FRALEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-08-6974A</b>		17. INFORMANT <b>WASHINGTON, D.C.</b> <b>ROBERT O. STONE</b> <b>1445 OGDEN ST. NW.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio sclerotic Cardio-Vasc. Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>June, 1953</b> to <b>7 June, 1957</b> , that I last saw the deceased alive on <b>3 June, 1957</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Barnesville, Maryland</b> DATE SIGNED <b>8 June 57</b> ACTUAL SIGNATURE <b>Gordon N. Smith</b> M.D. NAME (Type) <b>Gordon N. Smith</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion</b>	
22d. LOCATION (City, town, or county) (State) <b>Freagville Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton</b> ADDRESS <b>Barnesville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>6/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>Charles W. Elgin</b> <i>per J. E. S.</i>	

Abstract of the original document

BUREAU V. E.

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6587

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>4773 24th Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Virginia Hodgson SUTLIFF</b>				4. DATE OF DEATH Month Day Year <b>June 5 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 15, 1908</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Frank B. HODGSON</b>				14. MOTHER'S MAIDEN NAME <b>Kathryn POWELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>(Husband) Robert C. SUTLIFF (Same As #2)</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b) and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circumstances, fatal, due to</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Disruptive Circumstances, Rt Breast</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 30, 1957</b> , to <b>June 5, 1957</b> , that I last saw the deceased alive on <b>June 5, 1957</b> , and that death occurred at <b>3:10A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 6-5-57</b>							
ACTUAL SIGNATURE <b>T.S. DUNN, JR.</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>T.S. DUNN, JR., LT, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gawler &amp; Sons</b>				ADDRESS <b>1750 Penn. Ave., N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>6-5-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Harry B. Parrelly</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

JUN 6 1957

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## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glencove 62x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, write name of institution) <b>The Clinical Center</b>		d. STREET ADDRESS (No street address)	
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Alice</b> Last <b>Steines</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 April 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs		10. F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mathis Lehmann</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Huncke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b> DUE TO <b>ARTERIAL SCLEROSIS, SEVERE, EASHD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>PNEUMONIA, LEFT LOWER LOBE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>8 Mo 5 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>1-2-5</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 27, 1957</b> , to <b>June 8, 1957</b> , that I last saw the deceased alive on <b>June 8, 1957</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gurston Goldin</b> M.D.		DATE SIGNED <b>6/9/57</b>	
PHYSICIAN'S NAME (Type) <b>Gurston Goldin, M.D.</b>		The Clinical Center National Institutes of Health Bethesda 14, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town or county) (State)
<b>Burial-Transat</b>	<b>6-10-57</b>	<b>Bethel Cemetery</b>	<b>St. Louis County, Missouri</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6-11-57</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 12 1957

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6539

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If inst. before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>55 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>			
f. STREET ADDRESS <b>108 Wythe Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Hershel</b> Last <b>Strange</b>				4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>1957</b>			
5 SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>16 August 1909</b>	
9. AGE (In years and birthday) <b>47 yrs</b>		f. UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>		IF UNDER 24 HRS. Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry Lyles</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Dorsey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix uteri &amp; direct extension to all pelvic organs &amp; extensive spread</b> DUE TO (b) <b>metastasis in all abdominal structures</b> DUE TO (c) <b>metastasis in all abdominal structures</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right hyponephrosis &amp; small &amp; large bowel obstruction</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <input type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>(County) (State)</b>	
21. I certify that I attended the deceased from <b>April 2, 1957</b> , to <b>June 3, 1957</b> , that I last saw the deceased alive on <b>June 3, 1957</b> , and that death occurred at <b>5.00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b> DATE SIGNED <b>6/5/57</b>							
ACTUAL SIGNATURE <b>Chester Z. Haverback</b>				PHYSICIAN'S NAME (Type) <b>Chester Z. Haverback, M. D.</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>6/5/57</b>				22b. DATE THEREOF <b>6/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda</b>	
22d. LOCATION (City, town, or county) <b>Alexandria Va.</b>				22e. LOCATION (City, town, or county) <b>Alexandria Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arnold Thaw</b>				24a. REC'D BY REGISTRAR DATE <b>6/6/57</b>		24b. REG. STRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 11 1967

BUREAU V. S.

6590

CERTIFICATE OF DEATH

06577

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>704 Roeder St</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH K TAYLOR</b>				4. DATE OF DEATH Month Day Year <b>June 15 1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 28 1868</b>	9. AGE (In years last birthday) <b>88</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>S. Mason</b>				14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Charlotte Goble</b> Address <b>704 Roeder St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>322X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <b>10-23</b> , 1951, to <b>6-15</b> , 1957, that I last saw the deceased alive on <b>6-14</b> , 1957, and that death occurred at <b>10:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W B Wardrop</b>				ADDRESS (Street, city or town, state) <b>837 Bonifant St Silver Spring Md</b>			
PHYSICIAN'S NAME (Type) <b>W. B. WARDROP</b>				DATE SIGNED <b>6/15/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Swetland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Heap Funeral Home</b>				ADDRESS <b>4812 La Ave</b>		24a. REC'D BY REGISTRAR <b>JUN 20 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Frances Tully</b>			

UN 20 1957

TAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6591

## CERTIFICATE OF DEATH

06578 J16  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
c. LENGTH OF STAY in 1b <u>7 HRS</u>				d. STREET ADDRESS <u>4017 VANNESSE ST. NW.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DWIGHT</u> Middle <u>KIGGINS</u> Last <u>TERRY</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 10-1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. POST OFFICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. DC</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>GEORGE E. TERRY</u>			
14. MOTHER'S MAIDEN NAME <u>SARA KIGGINS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give year or dates of service) <u>1917-</u>			
16. SOCIAL SECURITY NO. <u>1917-</u>				17. INFORMANT <u>Mrs. HELEN TERRY (WIFE)</u> Address <u>4017 VANNESSE WASH. DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive cerebro-pontine hemorrhage</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO <u>years</u> (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Congenital Polycystic Kidneys</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Hour a. p. <u>None</u> Month <u>None</u> Day <u>None</u> Year <u>1957</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1955</u> 19... to <u>present</u> 19... that I last saw the deceased alive on <u>6/14/57</u> 19... and that death occurred at <u>1259 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>John B. Umhau</u> M.D.				ADDRESS (Street, city or town, state) <u>8805 Conn. Ave Chevy Chase Md</u>			
DATE SIGNED <u>6/14/57</u>				DATE SIGNED <u>6/14/57</u>			
22a. BURIAL CREMATION <u>burial</u>		22b. DATE THEREOF <u>6/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>17 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>			



BUREAU V

17 1953

RECEIVED

1 DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6592

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06579

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac river near Great Falls</u>		d. STREET ADDRESS <u>2833-27th St., N. W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE KELBY THOMAS</u>		4. DATE OF DEATH Month Day Year <u>June 17, 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1927</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Horace Kelby Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Ethel Lee Allison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Korean</u>	
17. INFORMANT <u>William R. Thomas</u>		Address <u>Same as Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia by Drowning</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>SR</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Drown while swimming in Potomac River</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:00 p. m.</u> <u>6-17-57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Item #1</u>		20f. (City or town) (County) (State) <u>Potomac</u> <u>Mtg.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>June 23, 1957</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCART</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>6-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

RECEIVED

JUN 26 1957

RECEIVED

MEDICAL CERTIFICATION

VS. AISME(5)  
SM 9/55

RECEIVED

JUN 2 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6594

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06581

Reg. Dist. No.

213

1. PLACE OF BIRTH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Off Md.R-355 1 1/2 mi. W. Clarksburg</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Ill.</b> b. COUNTY <b>Berwyn</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berwyn</b> d. STREET ADDRESS <b>6637 W. 21st.</b>		e. IS RESIDENCE ON A FARM? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert Kenneth Thomas</b>		4. DATE OF DEATH <b>6/22/57</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/26/27</b>	
9. AGE (In years last birthday) <b>30</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Co-Pilot</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Air Lines</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Illinois</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Florence Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>354-16-6432</b>		17. INFORMANT <b>Capital Airline Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple Injuries, Extreme</b> DUE TO <b>Body &amp; Extremities badly Mutilated</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Body &amp; Extremities badly Mutilated</b> DUE TO (c) <b>Body &amp; Extremities badly Mutilated</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Airplane Accident</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Airplane Accident</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Airplane Accident</b>			
20c. TIME OF INJURY Month, Day, Year <b>6/22/57</b> Hour a. m. <b>9:00</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>country</b>	
20f. (City or town) <b>Clarksburg</b>		20g. (County) <b>Montg. Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/22/57</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Milwaukee</b>	
22d. LOCATION (City, town, or county) <b>Wisconsin</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 25 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Ernest C. Gartner</b>					

RECEIVED

JUN 25 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar from burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X. Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10410 Fawcett Street</u>				d. STREET ADDRESS <u>10410 Fawcett Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>N.</u> Middle <u>TRADER</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27 1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR: Months <u>8</u> Days <u>27</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob P. Norlin</u>				14. MOTHER'S MAIDEN NAME <u>Jeanette Frost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary F. Dyott-Easton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Papillary Carcinoma Left Breast</u> 7 yrs INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>1950</u> 19 <u>June 24</u> 19 <u>1957</u> that I last saw the deceased alive on <u>June 23</u> 19 <u>1957</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u> DATE SIGNED <u>6/24/57</u> ACTUAL SIGNATURE <u>Marion Bankhead</u> PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>6/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Sedalia, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Fumhrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>6-27-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Hornfey</u>			



BUREAU V. S.

JUL 1 1957

RECEIVED

6596

## CERTIFICATE OF DEATH

Reg. Dist. No. 2.126

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4829 Flanders Ave (Garrett Park)</b>				d. STREET ADDRESS <b>4829 Flanders Ave. (Garrett Park)</b> <input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) <b>WILLIAM PERRY TRAIL</b>				4. DATE OF DEATH <b>June 18, 1957</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 13, 1906</b>	
9 AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>5</b>		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>Wm. P. Trail</b>				14. MOTHER'S MAIDEN NAME <b>Alethia E. Poole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs Mary N. Trail-Item # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY + H ROM BOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONGESTIVE HEART FAILURE</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>ONE HOUR</b> <b>15 YEARS</b> <b>10 YEARS</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>JAN-10, 1957</b> , to <b>JUNE 18, 1957</b> , that I last saw the deceased alive on <b>JUNE 18, 1957</b> , and that death occurred at <b>4:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.				ADDRESS (Street, city or town, state) <b>26 N. SUMMIT AVE Gaithersburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>				DATE SIGNED <b>19 JUN 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>6-24-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

RECEIVED

JUN 26 1957

BUREAU V. A.

6597

## CERTIFICATE OF DEATH

06584

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
c. LENGTH OF STAY IN 1b <b>61 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>800 New Hampshire Avenue</b>	
3 NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Virginia</b> Last <b>Utermoehlen</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 57</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>September 24, 1910</b>
9 AGE (In years lost birthday) <b>46 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>46</b> Days <b>46</b> Hours <b>46</b> Min <b>46</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Variety Store</b>	
11 BIRTHPLACE (State or foreign country) <b>Williams, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Daniel G. Mumma</b>		14 MOTHER'S MAIDEN NAME <b>Theresa Zimmerley</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>577-05-2554</b>	
17 INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma left pleura - with</b> DUE TO <b>massive pleural effusion &amp; atelectasis, expiratory.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Bowel obstruction - 2° to adhesions</b> DUE TO <b>around ileum</b> (c) <b>etc.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sleeve cutaneous fecal fistula - to Rt lower Quadrant</b>			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>&amp; vaginitis</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1</b> , 19 <b>57</b> , to <b>June 1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 1</b> , 19 <b>57</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chester Z. Haverback</b>		DATE SIGNED <b>6-2-57</b>	
PHYSICIAN'S NAME (Type) <b>CHESTER Z. HAVERBACK, M. D.</b>		ADDRESS <b>The Clinical Center National Institutes of Health Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 5, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Prince Geo. Co., Md.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Rumphrey</b>		24a. REC'D BY REGISTRAR <b>June 6-5-57</b>	
ADDRESS <b>Silver Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06585

## CERTIFICATE OF DEATH

6598

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
c. LENGTH OF STAY IN 1b <b>98 days</b>				d. STREET ADDRESS <b>1656 West Virginia Ave., N.E.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Agnes Catherine Vanne</b>		First Middle Last		4. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 26, 1909</b>	9. AGE (In years last birthday) yrs. <b>47</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Schlosser</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Loehman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronoid of artery</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 15, 1957</b> , to <b>June 21, 1957</b> , that I last saw the deceased alive on <b>June 21, 1957</b> , and that death occurred at <b>6:00 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>S. Weissman M.D. The Clinical Center 6/21/57</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>24 June 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Home Wash.</b>		22d. LOCATION (City, town, or county) (State) <b>DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home 4 + more are on pg</b>				24a. REC'D BY REGISTRAR <b>6-25-57</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

BUREAU V. S.

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6599

## CERTIFICATE OF DEATH

06586

Reg. Dist. No. 2.16

1. PLACE OF DEATH o COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>4 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>			
				d. STREET ADDRESS <u>4713 DRUMMOND AVE</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN CURTIS</u> First Middle Last <u>WALKER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-6-1897</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>APPRAISER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (State or foreign country) <u>WASH DC.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN C. WALKER</u>				14. MOTHER'S MAIDEN NAME <u>JENNIE YOUNG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1917-</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
				17. INFORMANT Address <u>CLAXTON WALKER-SON</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Coma and Insufficiency</u> DUE TO <u>Portal cirrhosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Nephrosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 15</u> , 19 <u>57</u> , to <u>June 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 15</u> , 19 <u>57</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above							
ACTUAL SIGNATURE <u>George A. Grey, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Chevy Chase Drive</u> DATE SIGNED <u>6/16/57</u>			
PHYSICIAN'S NAME (Type) <u>George A. Grey, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>6-24-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	



112C

BUREAU V. S.

JUN 26 1957

RECEIVED

6600

## CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>				c. LENGTH OF STAY IN 1b <b>2 yrs 11½ mo.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home for the Aged</b>				d. STREET ADDRESS <b>8338 Liberty Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Margaret</b> Last <b>Ward</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1879</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours M'n.	IF UNDER 24 HRS Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Rockdale, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Martin Luther Jean</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Rebecca Lynch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Asbury Home records</b>		Address <b>Gaithersburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO <b>4445 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>hypertension Cardiovascular heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2212</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>6-24</b> , 19 <b>57</b> , to <b>6-28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-28-</b> , 19 <b>57</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4208 Anthonys ST Kensington Md.</b> DATE SIGNED <b>6-28-57</b>							
ACTUAL SIGNATURE <b>Sarah E. Glover</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/15/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tucker &amp; Sons - Baltor</b>				24a. REC'D BY REGISTRAR <b>JUL 1 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred J. Hodge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

L. B. 1057

RECEIVED

6601

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>36 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9027 GEORGIA AVE</u>		d. STREET ADDRESS <u>9027 GEORGIA AVE</u> * IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>LEWIS</u> Last <u>WATERS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 19, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WENS CLOTHING</u>	
11. BIRTHPLACE (State or foreign country) <u>EDMON, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOS. WATERS</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA DAWSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>ALICE HENRIETTA WATERS</u>		Address <u>SILVER SPRING, MD</u> <u>9027 GEORGIA AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>IX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cerebro-arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 WKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic resection April 1957</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 1956</u> to <u>JUNE 25, 1957</u> that I last saw the deceased alive on <u>6-24</u> , 19 <u>57</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. M. Ballinger</u> M.D.		ADDRESS (Street, city or town, state) <u>1801 Eye St. N.W. WASH. DC</u> DATE SIGNED <u>6-25-57</u>	
PHYSICIAN'S NAME (Type) <u>WM. M. BALLINGER</u>		<u>1801 EYE ST. N.W. WASH. DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 27, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BURTONSVILLE, MONTGOMERY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. Ballinger</u> ADDRESS <u>254 CARROLL ST. N.W. DC</u>		24a. REC'D BY REGISTRAR <u>JUN 28 1957</u> 24b. REGISTRAR'S SIGNATURE <u>James P. Ballinger</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 28 1957

BUREAU V. S.

Handwritten notes and signatures, including "JUN 28 1957" and "BUREAU V. S." in reverse.

6459

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>15 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Son. Hosp.</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
f. STREET ADDRESS <i>1008 South Mansion Dr</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Frederick Warfield</i>				4. DATE OF DEATH <i>June 2 1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/29/82</i>	9. AGE (In years last birthday) <i>74</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>electrical contractor Self-employed</i>				11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>John Albert Warfield</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Stunkle</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO		17. INFORMANT Address <i>Hosp Records</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infects of lungs, recent</i>							<i>few days</i>
DUE TO <i>Embolic of pulmonary arteries</i>							" "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Heart Disease of uncertain type (? endocardial fibroelastosis)</i>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>Mar. 10 1957</i> to <i>June 2 1957</i> , that I last saw the deceased alive on <i>June 2 1957</i> , and that death occurred at <i>1:40 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Chas. W. Harnsberger</i> M.D.				ADDRESS (Street, city or town, state) <i>4201 NEW HAMPSHIRE AVE. N.W.</i>			
PHYSICIAN'S NAME (Type) <i>CHAS. W. HARNSEBERGER WASHINGTON D.C.</i>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>6/5/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>PRINCE GEORGE COUNTY, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Humphrey</i>				ADDRESS <i>SILVER SPRING, MD</i>		24a. REC'D BY REGISTRAR <i>J. M. Doherty</i>	
						24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1971

BUREAU V. S.

6692

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montg</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookmount</b>		c. LENGTH OF STAY IN 1b <b>1yr</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>6430 Brooks Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Rose</b> Last <b>Watkins</b>		4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 21-1874</b>
9. AGE (In years last birthday) <b>82 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Basil Buxton</b>		14. MOTHER'S MAIDEN NAME <b>Lavenia Brandenburg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs John H. Shuemaker.</b>		Address <b>6430 Brookslane Washing 16</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO <b>Arteriosclerosis, Hypertension 3 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, Hypertension 3 years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 25, 1957</b> to <b>June 14, 1957</b> , that I last saw the deceased alive on <b>June 12, 1957</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Rudnai</b> M.D.		ADDRESS (Street, city or town, state) <b>5120 New Arthur Rd. Washington D.C.</b> DATE SIGNED <b>6/14/57</b>	
PHYSICIAN'S NAME (Type) <b>ANDREW E. RUDNAI</b>			
22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-16-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Montgomery</b>	22d. LOCATION (City, town, or county) (State) <b>Damascus Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-18-57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



REAU V. S.

JUN 20 1957

RECEIVED

6603

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06591

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>FRANKLIN &amp; WIRE AVE. at Bus Stop</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>6 SILVER SPRING</b>			
f. STREET ADDRESS <b>9113 WIRE AVENUE</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>A</b> Last <b>WATKINS</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/31/03</b>	
9. AGE (In years to birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>13</b> Hours <b>19</b> Min. <b>57</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DELIVERY CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Woodward &amp; Lothrop Department Store</b>			
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>HERBERT A. WATKINS</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELLEN CALLAHAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>577-10-6152</b>			
17. INFORMANT <b>Miss Regina C. Watkins, 9113 Wire Ave.</b>				Address <b>Silver Spring, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1 IMMEDIATE CAUSE (a) Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> (c) <b>Sudden</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/15/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ward &amp; Humphrey</b>				ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>6/17/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Francis L. Lister</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the date and time of writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Or: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JUN 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

6604

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Westchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Aurora</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USNH, NNMC, BETHESDA, MARYLAND</b>				d. STREET ADDRESS <b>71 Glen Ridge Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>William</b> Last <b>WERTMAN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 May 1936</b>		9. AGE (in years last birthday) <b>21</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur WERTMAN</b>				14. MOTHER'S MAIDEN NAME <b>Thelma VALLES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>4-12-56-6-15-57 112 30 6490</b>		17. INFORMANT <b>Official Navy Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>102.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of C-5 with laceration of cord</b> DUE TO (c) <b>24 hours</b> <b>42 hours</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>42 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dived from eight foot board into shallow water while swimming</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>3:30</b> p. m. <b>6-13 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Timberlake</b>		20f. (City or town) (County) (State) <b>Oaktone Virginia</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				DATE SIGNED <b>16 June 1957</b>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-21-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Saint Matthews Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Buffalo New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				24a. REC'D BY REGISTRAR <b>6-17-57</b>			
ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md</b>				24b. REGISTRAR'S SIGNATURE <b>May C. Garrison</b>			

RECEIVED

JUN 19 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 6605 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

06593

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write, RURAL and give nearest town) <u>RD 1 Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Rest Home, RD 1, Silver Spring</u>		d. STREET ADDRESS <u>1107 Ardurich Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Blanche</u> First <u>White</u> Middle <u>White</u> Last		4. DATE OF DEATH <u>6-25-1957</u> Month <u>6</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-93</u> 64 yrs. Month <u>6</u> Day <u>2</u> Year <u>1993</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Anderson S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hawthorne Brown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Medical Records</u> Address <u>Mont. County H.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arthritis, Ankylosing of Spine, Chronic Con. fail.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-17-57</u> to <u>6-25-57</u> , that I last saw the deceased alive on <u>6-19-57</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u> ADDRESS (Street, city or town, state) <u>RD 1 Gaithersburg, Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>CLIVE E. JACKSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>6-25-57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Virginia Pollins</u> ADDRESS <u>4339 Hunt Rd.</u>		24a. REC'D BY REGISTRAR <u>6/30/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Frances Latta</u>	

W. A. C. 1957

1957

W. A. C. 1957

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6696

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06594

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B &amp; O RR tracks near N. Takoma R R Bridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
				d. STREET ADDRESS <b>1103 5th St. N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sandy</b> Middle <b>White</b> Last				4. DATE OF DEATH Month <b>6/7/57</b> Day <b>19</b> Year			
5. SEX <b>male</b>		6. COLOR OR RACE <b>ool</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/5/1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>M.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mary White 11-3 5th St, N. W. Wash. D. C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral and Thoracic Hemorrhage</b> DUE TO <b>Fracture of skull and Crushed chest (rt)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Compound Fracture of rt elbow</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Apparently struck by train while sitting along RR tracks</b>					
20c. TIME OF INJURY Month, Day, Year <b>6/7/57</b> Hour a. m. <b>11</b> m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B&amp;O RR</b>		20f. (City or town) (County) (State) <b>Silver Spring Montg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/7/57</b>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Morris Carter Funeral Home, Washington, D. C.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert K. Sworden</i>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 13 1957</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION



RECEIVED

11 13 1957

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6697

## CERTIFICATE OF DEATH

06595

Reg. Dist. No.

210

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>405 Pershing Drive</b>				e. STREET ADDRESS <b>405 Pershing Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Agnes</b> Last <b>Foley Wilcox</b>				4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/8/1900</b>	9. AGE (In years last birthday) <b>57</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Thomas F. Foley</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Connell</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Francis M. Wilcox-405 Pershing Drive Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>August 1940</b> to <b>June 20, 1957</b> , that I last saw the deceased alive on <b>June 20, 1957</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. C. Kirchner</b>			ADDRESS (Street, city or town, state) <b>6480-N.W. Ave Takoma Park Md</b>				
PHYSICIAN'S NAME (Type) <b>R. C. KIRCHNER</b>			DATE SIGNED <b>JUN 21 1957</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/24/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. 2901 14th St., N.W. DC</b>			24a. REC'D BY REGISTRAR <b>JUN 21 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Francis M. Wilcox</b>		

BUREAU V. A.

UN 11 1957

RECEIVED

6608

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY <b>Montgomery County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>DAUPHIN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WAYNE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cedarcroft Sanitarium and Hospital</b>		d. STREET ADDRESS <b>336 CONESTOGA ROAD</b> <b>12101 Columbia Pike</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Richard Francis Wood, Jr.</b>		4. DATE OF DEATH Month Day Year <b>June 20 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 1, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Broker - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pennsylvania</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Francis Wood</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Leaming</b> Surname -- <b>Leaming</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Mexican - 1st World</b>	
17. INFORMANT <b>Edwin Borsack, Jr., 432 Aryle Drive, - Va.</b>		Address <b>Falls Ch.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4:20.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>General arterio Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>a few minutes</b> <b>2</b> <b>2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arterio-sclerosis &amp; psychosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1957</b> , to <b>June 20, 1957</b> , that I last saw the deceased alive on <b>June 19, 1957</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Alvin J. Kistler</b>		DATE SIGNED <b>June 20, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Alvin J. Kistler, M. D.</b>		ADDRESS <b>Cedarcroft Sanitarium &amp; Hospital, Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Trans. &amp; Burial</b>	22b. DATE THEREOF <b>6/24/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Old Saint David's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Devon, Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Adams &amp; Humphrey</b>		24a. REC'D BY REGISTRAR DATE <b>July 1/57</b>	
24b. REGISTRAR'S SIGNATURE <b>James C. Potts</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6609

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06596

Reg. Dist. No. 286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institutions: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 15 <u>1 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6901 Armat Dr.</u>				d. STREET ADDRESS <u>6901 Armat Dr.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Maria Beaud Worrall</u>				4. DATE OF DEATH Month Day Year <u>6-19-57</u> 19			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-27-80</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Christian Scientist Practitioner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Beaud</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Woodward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mary W. Edwards - Thur 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Chronic Cardio-renal disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland M.D.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler Sons</u>		ADDRESS <u>1756 Penna Ave NW</u>		24a. REC'D BY REGISTRAR <u>DATE 6-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED  
JUN 24 1957  
BUREAU V. S.

6610

## CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <b>Montg</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg.</b>		c. LENGTH OF STAY IN 1b <b>25yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Gaithersburg</b>	
d. STREET ADDRESS <b>14 E. Diamond Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lydia</b> Middle <b>Anna</b> Last <b>Younkins</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 7-1888</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR: Months <b>6</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Middletown. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Martin L. Flook</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jennings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>L. Reynolds Younkings. Gaithersburg. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIAL HYPERTENSION</b> DUE TO (c) <b>ARTERIO SCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 HOURS</b> <b>10 YRS</b> <b>10 &amp; 12.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>450.0</b> <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 1, 1957</b> to <b>JUNE 17, 1957</b> that I last saw the deceased alive on <b>JUNE 17, 1957</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1/24/57</b>			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.		PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b> <b>Gaithersburg. Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-19-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner, Gaithersburg. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>June 18-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles L. Coole</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK  
CERTIFICATE OF DEATH

BUREAU V. S.

JUN 21 1957

RECEIVED